PSRO PROPOSALS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

S. 1250, S. 2142

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PSRO PROPOSALS

THURSDAY, APRIL 1, 1982

U.S. SENATE,
COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman of the subcommittee) presiding.

Present: Senators Durenberger, Dole (chairman of the full committee), Baucus, and Bradley.

Senator DURENBERGER. The hearing will come to order. I am pleased that we were able to schedule this hearing today. Last year at about this same time we held a hearing on the proposed phaseout of the PSRO program, and this is not a hearing to rehash that issue. This subcommittee and the Congress carefully considered and rejected that proposal last year.

In place of outright repeal, we reconfirmed our support for effective peer review, while eliminating support for poor performers in that area.

[The committee's press releases announcing this hearing, the bills S. 1250 and S. 2142, and the prepared statements of Senators Durenberger and Dole follow:]

[Press release No. 82-110 Mar. 9, 1982]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON PROPOSALS TO MAKE IMPROVEMENTS IN PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO'S)

The Honorable Dave Durenberger (R., Minnesota), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the subcommittee will hold a hearing on the Professional Standards Review Amendments of 1981 (S. 1250) introduced by Senator Max Baucus (D., Montana) and the Peer Review Improvement Act of 1982 (S. 2142) introduced by Senators David Durenberger, John Heinz (R., Pennsylvania) and Daniel Patrick Moynihan (D., New York). The hearing will begin at 9:30 a.m., Friday, March 26, 1982 in Room 2221 of the Dirksen Senate Office Building.

Senator Durenberger noted that there are effective PSRO's as well as ineffective ones. "Last year", the Senator said, "we passed legislation that would eliminate the poor performers. This year we need to redirect and simplify the procedures under which review services are performed. With health care costs continuing to escalate at alarming rates, we need all the help we can get in assuring the effective, efficient and economical delivery of quality health care services. Private sector peer review can have a significant effect on helping to meet those objectives".

Requests to testify.—Witnesses who wish to testify at the hearing must submit a written request to Robert E. Lighthizer, Chief Counsel, Committee on Finance, Room 2227, Dirksen Senate Office Building, Washington, D.C. 20510, to be received no later than noon on Friday, March 19, 1982. Witnesses will be notified as soon as practicable thereafter whether it has been possible to schedule them to present oral testimony. If for some reason a witness is unable to appear at the time scheduled, he may file a written statement for the record in lieu of the personal appearance. In such a case, a witness should notify the committee of his inability to appear as soon as possible.

[Press release No. 82-110 (revised) Mar. 17, 1982]

SENATE FINANCE SUBCOMMITTEE ON HEALTH RESCHEDULES HEARING ON PROPOSALS TO MAKE IMPROVEMENTS IN PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO's)

The Honorable Dave Durenberger (R., Minnesota), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the subcommittee's hearing originally scheduled for Friday, March 26, 1982, at 9:30 a.m. in Room 2221, Dirksen Senate Office Building has been rescheduled for Thursday, April 1, 1982 at 9:30 a.m. The subject matter and location of the hearing will remain the same as originally announced.

OPENING STATEMENT OF SENATOR DOLE

I can only say that I, like Senator Durenberger, believe that the Federal Government should be a prudent buyer—not only because we pay the bill for most of the medical services provided in this country and have a responsibility to the taxpayer in seeing that spending is contained—but, just as importantly, because we have a responsibility to each and every citizen who becomes a patient under Federal programs.

We should avail ourselves of the kinds of mechanisms used by the private sector, mechanisms which control costs and yet ensure the continued quality of care standard that this country has attained, a quality of care which we owe each citizen.

As I am sure you are all aware, the President and his advisors have stressed the absolute necessity of discipline on spending, and Federal health programs are a highly visible target for reductions. Such reductions are coming, and yet we must make certain that those reductions do not translate into inadequate or lesser quality care.

Let me reiterate Senator Durenberger's point. This committee supports the concept of professional review as both a cost containment and quality assurance mechanism. We need to improve on the concept as it was contained in the PSRO program. I believe the legislative proposals being considered this morning will do just that.

OPENING STATEMENT OF SENATOR DURENBERGER

I am pleased that we were able to schedule this hearing today. Last year at about this same time we held a hearing on the proposed phaseout of the PSRO program. This is not a hearing to rehash that issue. This Committee and the Congress carefully considered and rejected that proposal.

In place of outright repeal, we reconfirmed support for effective professional standards review while eliminating support for the poor performers. The purpose of this hearing is to take testimony on proposed legislation designed to redirect and simplify the procedures under which review services are performed, enhance the cost-effectiveness of the process, and stimulate private sector involvement.

I am pleased to be joined by my distinguished colleague Senator Baucus, ranking minority member on the Subcommittee on Health, in sponsoring legislative proposals to make major improvements in the program. Although we have offered different approaches, the proposals are identical in intent—to improve upon a concept that has and can continue to assure that quality health care be provided in an economical manner.

We, as members of Congress, have a responsibility to the American people to assure that our increasingly scarce health care dollars are spent effectively, efficiently, and economically.

I would be among the first to agree that peer review is not the "end all be all" solution to this concern—it is at best a partial solution. Nonetheless, we simply cannot afford to turn away from the many dedicated physicians in this country who are trying to help their government with the serious problems we face in financing health care services.

This help is not restricted to just Medicare and Medicaid. It is encouraging to me to see the results being accomplished by private employers and insurers as a result of their contracts with PSRO's. Surely, the Federal Government as the largest purchaser of health care services should be able to enjoy the same level of success. We hope to hear testimony today on how to accomplish that objective.

Senator **Durenberger**. The purpose of this hearing is to take testimony on proposed legislation designed to redirect and simplify the procedures under which review services are performed, enhance the cost-effectiveness of the process, and stimulate private sector involvement in peer review.

I am pleased today to be joined by my distinguished colleague Senator Baucus, who is the ranking minority member of the Subcommittee on Health. Both of us have sponsored legislative proposals to make major improvements in this program. We have offered somewhat different approaches, but I think the proposals we have offered are identical in their intent. That is, to improve on a concept that has and can continue to assure that quality health care be provided in an economical manner.

We as Members of the Congress have a responsibility to the American people to assure that our increasingly scarce health care dollars are spent effectively, efficiently, and economically. I would be among the first to agree that peer review is not the end all and be all solution to this concern. It is at best, just part of the solution. Nonetheless, we simply cannot afford to turn away from the many dedicated physicians in this country who are trying to help all of us with the serious problems that we face in financing access to quality health care in this country.

This help is not restricted to just medicare and medicaid. It is encouraging to me to see the results being accomplished by private employers, by insurers, as a result of their ever-increasing contracts with the existing peer review organizations.

Surely the Federal Government, as the largest purchaser of health care services, should be able to enjoy the same level of success that employers and insurers are demonstrating to us in their work with those dedicated physicians out there in this country.

We will hear testimony today; it is incredible the number of people who wanted to testify today. Time limits the number of people we can hear from and also it limits each of those who will be testifying in the amount of time we are going to be able to give you.

But as you all know in dealing with both of us, we are very open-minded people. We are looking for answers, as are the rest of the members of the Senate Finance Committee, as I am sure the chairman has and will demonstrate to you repeatedly.

This hearing and other opportunities to have input into the process will remain open so that we can accomplish in an appropriate manner the objectives that I set out earlier in my statement.

Max, do you have an opening statement you would like to give?

Senator **Baucus**. Mr. Chairman, as you mentioned, this subcommittee met 1 year ago almost to the day to review the administration's proposal to phase out PSRO's, and we in the Senate concluded that the program should be strengthened, not eliminated. I subsequently introduced S. 1250. Two of the provisions of that bill found their way into the Reconciliation Act that was later enacted that year. These provisions modified procedures for terminating ineffective PSRO's and eliminated the requirement that State medicaid programs rely on PSRO's.

More recently, the distinguished subcommittee chairman introduced a far-reaching revision of the PSRO statute, and I hope to see much of this bill made part of this year's legislation.

Over the past few years, the PSRO program has been the subject of numerous changes, some administrative, some legislative, reflecting the dynamic nature of the program.

It was only in 1978 that the PSRO program, after a slow start, was evaluated in a systematic fashion. The results were disappointing and showed net 1977 savings to the Government of only about $5 million. The report for the next year, 1978, showed considerable improvement, with savings of $21 million.

In the ensuing years, PSRO's have gained experience and have responded to the increasing pressure to perform effectively. Unfortunately, we have no Health Care Financing Administration evaluations of PSRO's cost effectiveness for this critical post-1978 period. However, reports compiled by the American Association of PSRO's indicated that by 1980, just 62 of the 184 PSRO's accounted for net savings of about $60 million.

Moreover, it has been only in the past few years that the poorer performers have been identified and dropped from the program. The number of PSRO's has been decreased from 187 to 147 in the last 12 months.

It has also been in the recent past that the growing success of PSRO's has gained the approval and support of private business. By mid-year, well over half the PSRO's are expected to have contracts with private businesses.

Mr. Chairman, my point is that the PSRO program is evolving rapidly and that these recent trends and developments will have an important bearing on any decisions that we reach about the future role of PSRO's and the use of possible alternative professional review mechanisms. I welcome this opportunity to receive an update on the performance of the PSRO's and join with you this morning in determining what steps if any we should next take.

Senator **Durenberger**. Thank you very much.

Our first witness this morning is Mr. George A. Thompson, Associate Administrator for Operations of the Health Care Financing Administration. George, you may proceed.

STATEMENT OF GEORGE A. THOMPSON, ASSOCIATE ADMINISTRATOR FOR OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY JAMES SCOTT, DIRECTOR OF THE OFFICE OF LEGISLATION AND POLICY; TERA YOUNGER, DIRECTOR OF THE BUREAU OF PROGRAM OPERATIONS; AND EDWARD KELLY, DEPUTY DIRECTOR OF THE HEALTH STANDARDS AND QUALITY BUREAU

Mr. **Thompson**. Mr. Chairman, it is a pleasure to be with you today to discuss PSRO's and the proposals that you and other members of the committee have made to change the direction of the program. We certainly share with you and the committee the need to control inappropriate utilization of costly health care services.

With me today I have Tera Younger, who is the Director of the Bureau of Program Operations. On my far left I have Ed Kelly, who is the Deputy Director of the Health Standards and Quality Bureau. On my immediate left is Jim Scott, the Director of our Legislative Office.

With your permission and to save time, I will submit my prepared statement for the record and summarize that statement at this time.

Senator DURENBERGER. Without objection, your full statement will be made a part of the record.

[The statement of Mr. Thompson follows:]

STATEMENT OF

GEORGE THOMPSON

ASSOCIATE ADMINISTRATOR FOR OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN, IT IS A PLEASURE TO BE HERE TODAY TO DISCUSS THE PROFESSIONAL STANDARDS REVIEW (PSRO) PROGRAM, THE AMENDMENTS TO THAT PROGRAM PROPOSED BY YOU AND OTHER MEMBERS OF THE SENATE FINANCE COMMITTEE, AND OUR MUTUAL CONCERN REGARDING THE NEED TO CONTROL INAPPROPRIATE UTILIZATION OF COSTLY HEALTH CARE SERVICES. WITH ME TODAY ARE JAMES SCOTT, DIRECTOR OF THE OFFICE OF LEGISLATION AND POLICY, TERA YOUNGER, DIRECTOR OF THE BUREAU OF PROGRAM OPERATIONS AND EDWARD KELLY, DEPUTY DIRECTOR OF THE HEALTH STANDARDS AND QUALITY BUREAU.

INTRODUCTION

TEN YEARS AGO THE PSRO PROGRAM WAS CREATED AND CHARGED WITH ASSURING THAT CARE PROVIDED TO MEDICARE AND MEDICAID PATIENTS WAS MEDICALLY NECESSARY, PROVIDED IN THE APPROPRIATE SETTING AND MET PROFESSIONALLY-RECOGNIZED STANDARDS. PSROs WERE SEEN AS AN IMPORTANT TOOL FOR CONTAINING PROGRAM COSTS BY DENYING PAYMENT FOR UNNECESSARY SERVICES AND DECREASING UTILIZATION THROUGH IMPROVED PATTERNS OF HEALTH CARE DELIVERY.

TODAY, AS WE REVIEW A DECADE OF PSRO ACTIVITIES, WE MUST CONCLUDE THAT THE PROGRAM HAS FAILED TO HAVE A SIGNIFICANT EFFECT ON CURBING THE COSTS OF FEDERALLY FINANCED HEALTH CARE. IN THE MEDICARE PROGRAM ALONE, COSTS CONTINUE TO ESCALATE TO A POINT WHERE THEY ARE CLEARLY RUNNING OUT OF CONTROL.

COSTS OF THE MEDICARE PROGRAM IN 1981 WERE $42.5 BILLION, AN INCREASE OF OVER 21 PERCENT FROM THE PREVIOUS YEAR. IN 1982, MEDICARE EXPENDITURES ARE PROJECTED TO REACH $49.8 BILLION, AN INCREASE OF OVER 17 PERCENT FROM 1981.

TWO-THIRDS OF MEDICARE BENEFITS ARE FOR INPATIENT HOSPITAL CARE WITH ANOTHER FIFTH PAYING FOR PHYSICIAN'S SERVICES. HOSPITAL LENGTHS OF STAY CONSISTENTLY RUN 50 PERCENT LONGER IN SOME REGIONS THAN IN OTHERS--FOR THE SAME DIAGNOSIS AND PROCEDURE, AND HOSPITAL ADMISSION RATES CONTINUE TO RISE, EVEN AS THE HEALTH OF THE ELDERLY CONTINUES TO IMPROVE. RECENT ESTIMATES BY THE MEDICARE HOSPITAL INSURANCE TRUSTEES PROJECT THAT PROGRAM OUTLAYS MAY EXCEED INCOME BY AS EARLY AS 1985.

IN INTRODUCING S. 2142, YOU EXPRESSED THE NEED FOR CONGRESS, THE ADMINISTRATION AND THE PRIVATE SECTOR TO WORK TO MODERATE THE COSTS OF THE MEDICARE PROGRAM, AND TO ASSURE THAT OUR DOLLARS ARE SPENT IN A FASHION WHICH PROVIDES FOR ACCOUNTABILITY. IN ADDITION, YOU HAVE BEEN ONE OF THE LEADERS IN THE CONGRESS IN SUPPORT OF BRINGING MORE COMPETITIVE, MARKET PLACE CONTROLS INTO THE FIELD OF HEALTH FINANCING AND DELIVERY. THE ADMINISTRATION SHARES THESE OBJECTIVES AND WE APPRECIATE THE OPPORTUNITY TO WORK WITH YOU AND THIS COMMITTEE AS WE SEEK TO DEVELOP NEW APPROACHES AND SOLUTIONS TO OUR DIFFICULT HEALTH CARE COST CONTAINMENT PROBLEMS.

LET ME TURN NOW TO THE BILLS BEFORE US TODAY. BOTH BILLS WOULD MAKE INNOVATIVE CHANGES IN THE BASIC STRUCTURE OF THE PSRO PROGRAM.

S. 2142, UTILIZATION AND QUALITY CONTROL PEER REVIEW ACT

S. 2142, INTRODUCED BY YOU, MR. CHAIRMAN, ALONG WITH SENATOR HEINZ AND SENATOR MOYNIHAN, PROPOSES TO REDIRECT, SIMPLIFY, AND ENHANCE THE COST-EFFECTIVENESS OF THE PSRO PROGRAM. IT WOULD DO THIS BY ESTABLISHING A PERFORMANCE-BASED CONTRACTING PROCEDURE TO REPLACE THE CURRENT FEDERAL GRANTS-SUPPORTED SYSTEM. THE INTENT IS TO MAKE THE FEDERAL GOVERNMENT A PRUDENT PURCHASER OF REVIEW SERVICES. THE SECRETARY WOULD HAVE THE AUTHORITY TO ENTER INTO PERFORMANCE-BASED CONTRACTS WITH PHYSICIAN ORGANIZATIONS OR WITH OTHER ORGANIZATIONS SUCH AS INTERMEDIARIES OR CONTRACTORS EMPLOYING A SUFFICIENT NUMBER OF PRACTICING PHYSICIANS TO CONDUCT PEER REVIEWS, AND COULD TERMINATE THESE CONTRACTS IF THEIR TERMS WERE NOT BEING MET. REVIEW ACTIVITIES COULD NOT BE DELEGATED TO HOSPTIALS.

S. 2142 WOULD ALSO CONSOLIDATE THE GEOGRAPHIC AREAS SERVED BY THESE REVIEW ORGANIZATIONS AND WOULD MAKE OTHER CHANGES DESIGNED TO SIMPLIFY THE PROGRAM.

S. 1250, PROFESSIONAL STANDARDS REVIEW AMENDMENTS OF 1981

SENATOR BAUCUS' BILL, S. 1250, INTRODUCED LAST YEAR, IS INTENDED TO MAKE THE PSRO PROGRAM MORE EFFICIENT BY CONSOLIDATING PSRO AREAS GENERALLY ON A STATE-WIDE BASIS. THE BILL WOULD REQUIRE FOCUSED REVIEW OF SERVICES WHERE INAPPROPRIATE UTILIZATION IS LIKELY TO OCCUR. IT WOULD ALSO HOLD CLAIMANTS LIABLE FOR PAYMENT IF THE PSRO HAD GIVEN PRIOR NOTICE ON INAPPROPRIATE UTILIZATION AND A REASONABLE TIME HAD ELAPSED TO CORRECT THE PROBLEM. SOME PROVISIONS IN S. 1250 WERE, OF COURSE, ENACTED AS PART OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981.

ON BALANCE, WE CONSIDER MANY OF THE CHANGES PROPOSED IN THESE TWO BILLS TO BE IMPROVEMENTS OVER THE PRESENT SYSTEM.

WE ARE PLEASED TO NOTE THAT MANY OF THE REFORMS YOU HAVE PROPOSED, MR. CHAIRMAN, ARE PHILOSOPHICALLY CONSISTENT WITH THIS ADMINISTRATION'S VIEWS. YOUR BILL ELIMINATES MANY OF THE DETAILED FEDERAL REQUIREMENTS WHICH, AS YOU HAVE POINTED OUT, HAVE SERVED TO LIMIT INNOVATIONS. IT IS ALSO A MOVEMENT IN A DIRECTION WE FAVOR; THAT IS, TOWARD A SYSTEM THAT IS LESS REGULATORY, AND ONE WHICH INTRODUCES A COMPETITIVE ASPECT INTO REVIEW ACTIVITIES AND SEEKS TO ASSURE THAT ONLY THE GOOD PERFORMERS ARE RETAINED.

THERE IS NO QUESTION BUT THAT WE SHARE A COMMON OBJECTIVE: TO DEVELOP A SYSTEM TO MODERATE THE COST OF THE MEDICARE PROGRAM AND ASSURE ACCOUNTABILITY OF THE DOLLARS SPENT.

ADMINISTRATION CONCERNS AND ALTERNATIVE APPROACHES

WE BELIEVE A MAJOR REFORM IS IN ORDER, ONE THAT DOES NOT MANDATE A NATION WIDE SYSTEM WHERE IT IS NOT NECESSARY, RESTRICT SELECTION OF REVIEW ORGANIZATIONS, OR REQUIRE DUPLICATIVE REVIEW PROCESSES. AFTER 10 YEARS, AND

MANY ATTEMPTS TO IMPROVE ITS EFFECTIVENESS, THE CURRENT PEER REVIEW ORGANIZATION SYSTEM HAS PROVEN TO BE, AT BEST, ONLY MARGINALLY COST-BENEFICIAL.

THE TWO NATIONAL EVALUATIONS OF THE PSRO PROGRAM, PERFORMED BY THE DEPARTMENT IN 1978 AND 1979, SHOWED CONSISTENTLY MARGINAL IMPACT OF PSRO REVIEW. ACCORDING TO THE 1979 STUDY, REVIEW RESULTED IN A 1.7 PERCENT REDUCTION IN MEDICARE DAYS OF CARE AND A RESULTING SAVINGS OF ABOUT 26 CENTS FOR EVERY DOLLAR SPENT. HOWEVER, THERE WAS WIDE VARIATION FOUND IN INDIVIDUAL PSRO PERFORMANCE WITH SOME PSROs HAVING LITTLE OR NO IMPACT ON UTILIZATION.

LIKEWISE, THE CONGRESSIONAL BUDGET OFFICE (CBO) ALSO ANALYZED THE DATA USED IN THE 1979 PSRO PROGRAM EVALUATION. CBO AGREED THAT SOME SAVINGS ACCRUED TO THE MEDICARE PROGRAM THROUGH DECREASED HOSPITAL UTILIZATION. HOWEVER, CBO FOUND THAT SOME OF THESE MEDICARE SAVINGS WERE PASSED ON AS COSTS TO PRIVATE PATIENTS AND THAT, OVERALL, PSROs COST SOCIETY SUBSTANTIALLY MORE THAN THEY SAVED.

WE ALSO WOULD NOTE THAT THE PSRO PROGRAM HAS IMPOSED A SUBSTANTIAL REGULATORY BURDEN ON HOSPITALS, PHYSICIANS AND MEDICARE CONTRACTORS. DUPLICATIVE SYSTEMS OF DATA COLLECTION AND PROCESSING ARE MAINTAINED TO MEET THE PSROs' NEED TO SUPPORT THEIR REVIEW FUNCTIONS AND THE CONTRACTORS' NEED TO PAY BENEFICIARY CLAIMS. IN ADDITION, ALL INVOLVED ORGANIZATIONS MUST MAKE SEPARATE REPORTS ON PSRO REVIEW ACTIVITIES AND COSTS TO THE FEDERAL GOVERNMENT. GIVEN THE REGULATORY BURDEN OF PSRO REQUIREMENTS, ALONG WITH THE DISAPPOINTING FINDINGS ON COST AND UTILIZATION CONTROL, WE MUST LOOK FOR A MORE PRODUCTIVE ALTERNATIVE TO THE CURRENT PSRO SYSTEM.

LAST YEAR, CONGRESS ELIMINATED MANDATORY PSRO REVIEW OF MEDICAID PATIENTS AND GAVE STATES THE FLEXIBILITY TO DESIGN THEIR OWN SYSTEMS TO CONTROL MEDICAID UTILIZATION. WE BELIEVE IT IS TIME WE ACTED TO END THE CURRENT PSRO SYSTEM AND WITH IT DIRECT FEDERAL SUPPORT OF THE PSRO PROGRAM AND THE FALLBACK SYSTEM OF INSTITUTIONAL UTILIZATION REVIEW (UR) FOR MEDICARE AND MEDICAID. INSTEAD, WE ARE PROPOSING ALTERNATIVE WAYS TO CONTROL UTILIZATION.

IN LIEU OF THE CURRENT FEDERALLY FUNDED PSRO AND UR SYSTEM, WE PROPOSE ADOPTION OF NEW APPROACHES TO CONTROLLING UTILIZATION. UNDER SUCH SYSTEMS, A STATE COULD CONTRACT WITH PSROs TO PERFORM REVIEW, IF IT BELIEVED THIS WOULD BE AN EFFECTIVE WAY TO CONTROL THE UTILIZATION OF MEDICAID SERVICES. IN FACT, ABOUT 20 STATES HAVE INDICATED TO US THAT THEY ARE ACTIVELY NEGOTIATING ARRANGEMENTS WITH PSROs.

WE WOULD ALSO IMPLEMENT A SYSTEM OF MEDICARE UTILIZATION REVIEW PERFORMED BY THE MEDICARE CONTRACTORS. UNDER THIS APPROACH, WHICH IS STILL BEING REFINED, CONTRACTORS WOULD APPLY EXPERIENCE DEVELOPED FROM THEIR NON-FEDERAL BUSINESS AND EXAMINE PROBLEM AREAS SUCH AS WEEKEND ADMISSIONS, MONDAY DISCHARGES, ONE DAY STAYS, OVERUSE OF ANCILLARY SERVICES, AND LONG PRE-OPERATIVE STAYS. CONTRACTORS WOULD BE ALLOWED TO DESIGN THEIR OWN PROGRAM OF REVIEW, BASED ON PSRO EXPERIENCE AND THEIR OWN ANALYSIS OF PROVIDER PERFORMANCE. FUNDING PRIORITY TO SUPPORT THIS REVIEW WILL BE GIVEN TO MEDICARE CONTRACTORS WHOSE HOSPITALS GENERALLY SHOW A RELATIVELY HIGHER LEVEL OF INAPPROPRIATE UTILIZATION THAN SIMILAR HOSPITALS IN OTHER AREAS. MEDICARE CONTRACTORS WILL NOT HAVE TO ESTABLISH A NEW DATA SYSTEM OR CARRY OUT THE BURDENSOME REQUIREMENTS REQUIRED BY PSRO REVIEW. THE INCREMENTAL COSTS OF USING CONTRACTORS AS WELL AS THE ADMINISTRATIVE BURDEN FOR ALL INVOLVED ORGANIZATIONS IS RELATIVELY LOW. WE WILL REQUIRE PERIODIC REPORTS OF PROGRESS IN ACHIEVING TARGETS, AND WILL MONITOR THESE CLOSELY.

OUR LEGISLATIVE PROPOSALS FOR MODIFYING MEDICARE CONTRACTING PROCEDURES, WHICH WE HAVE PREVIOUSLY DISCUSSED WITH THIS SUBCOMMITTEE, COMPLEMENT OUR PLANS FOR CONTRACTOR UTILIZATION REVIEW. THE REVISED CONTRACTING SYSTEM, WHICH WOULD STIMULATE INNOVATION AND COST EFFECTIVENESS IN CONTRACTOR OPERATIONS, WOULD ALSO RESULT IN INCREASED ACCOUNTABILITY OF CONTRACTORS IN ALL AREAS OF THEIR WORK, INCLUDING UTILIZATION REVIEW ACTIVITIES.

THE MEDICARE CONTRACTOR ACTIVITIES WILL BE COMPLEMENTARY TO EFFORTS IN THE PRIVATE SECTOR, WHICH IS NOW DEVELOPING COMMUNITY-BASED, LOCALLY LED HEALTH CARE COALITIONS AS THE FOCAL POINT FOR COST RESTRAINT. THESE COALITIONS ARE COMPOSED NOT ONLY OF HEALTH CARE PLANNERS AND PROVIDERS BUT ALSO OF LOCAL BUSINESS AND COMMUNITY LEADERS WORKING TOGETHER TO RESTRAIN DEMAND AND PRODUCE A MORE COST-EFFECTIVE HEALTH CARE SYSTEM.

CONCLUSION

WE ARE OPTIMISTIC ABOUT THE POTENTIAL THESE COMPLEMENTARY APPROACHES OFFER FOR CONTROLLING UTILIZATION. WE BELIEVE THAT MEDICARE CONTRACTORS AND MEDICAID STATE AGENCIES HAVE THE EXPERIENCE AND THE ABILITY TO CREATE A WORKABLE REVIEW SYSTEM, BUT WITHOUT THE REGULATORY BURDEN IMPOSED BY THE CURRENT SYSTEM. ACTIVITIES PROMOTED BY THE PRIVATE SECTOR EFFORTS WILL CERTAINLY PROMOTE A COOPERATIVE APPROACH FROM BOTH HEALTH CARE PROVIDERS AND CONSUMERS.

WE BELIEVE THIS COMBINATION OF FEDERAL, STATE AND PRIVATE EFFORTS WILL SUCCEED. IT INVOLVES NEW APPROACHES WHICH BUILD UPON PAST EXPERIENCE. EFFECTIVE PSROs CAN CONTINUE TO SELL THEIR SERVICES TO PUBLIC AND PRIVATE PURCHASERS, INCLUDING MEDICARE CONTRACTORS. BUSINESS AND INDUSTRY HAVE ALREADY SHOWN A DESIRE TO PURCHASE PSRO REVIEW SERVICES FOR THEIR HEALTH CARE PLANS. WE ALSO WILL REIMBURSE HOSPITALS AS PART OF THEIR OPERATING COSTS, FOR REVIEW SERVICES PURCHASED FROM A PSRO.

SUCCESS IS ESSENTIAL, FOR IF WE FAIL IN CONTROLLING COSTS, HOSPITALS, PHYSICIANS AND CONSUMERS MUST BE PREPARED FOR A RETURN TO A STRICT AND SEVERE REGULATORY APPROACH. WE ALL AGREE THAT SUCH A SYSTEM IS NOT DESIRABLE, AND WE WILL WORK WITH YOU TO ASSURE THAT AN EFFECTIVE AND EFFICIENT METHOD FOR CONTROLLING THE UTILIZATION OF HEALTH SERVICES IS IN PLACE.

MR. CHAIRMAN, IN SUMMARY, WHILE WE SUPPORT THE APPROACH IN THE PRESIDENT'S BUDGET, WE ARE WILLING TO CONTINUE THESE DICUSSIONS WITH YOU AS WE WORK TOWARD A SHARED OBJECTIVE. I WOULD BE PLEASED TO ANSWER ANY QUESTIONS YOU AND THE COMMITTEE MAY HAVE.

Mr. **Thompson**. Ten years ago today the PSRO program was enacted to insure that medicare beneficiaries receive proper medically necessary services in the appropriate setting that meets professional standards. A system was set up to review the practice of medicine and to influence and improve behavior patterns.

Today, with the cost escalation in health care continuing to run almost out of control, is an opportune time for us to rethink whether this mechanism is performing the correct functions.

Mr. Chairman, in introducing S. 2142, you expressed the need for Congress, the administration and the private sector to work together in moderating health care costs. In addition, you have been a leader in introducing legislation to promote competition in the marketplace in the health care world. The administration shares these views with you and feels that we can work together in implementing some of these objectives.

Turning to the bills we have before us today, S. 2142, introduced by you, Senator Heinz, and Senator Moynihan, redirects, simplifies and enhances the PSRO program. It introduces a competitive aspect into peer review, and rather than the grant supported process which we are operating under now the bill would establish a performance-based contracting process, with the expectation that only good performers could continue to contract for peer review service.

It also consolidates the areas in which peer review will occur, so that the area would be statewide or regional. This will save administrative costs and require fewer entities to be involved in the peer review system.

It also broadens the type of organizations which would be permitted to bid, so that not only the current PSRO's could bid, but also intermediaries or other organizations that have a sufficient number of physicians to do review which then enables a competitive action to take place.

Senator Baucus' bill also addresses service areas which we feel is something that should be addressed, and it requires focused review based on the good lessons we learned out of the PSRO experience we have had.

We are pleased to note with the many of the reforms in your bills are consistent with the administration's views.

Last year the Congress eliminated the mandatory PSRO review for medicaid and allowed the medicaid programs to set up the best type of review that is most cost-effective for them. I think it is time for us to eliminate the requirement for PSRO's or to substantially modify that approach, and to eliminate the UR system. Good PSRO's, in any change that is suggested either by the administration or your bills, could survive by contracting with the State, by contracting with private industry, by being one of the bidders in your peer review system, or by being a subcontractor with the contractors in our proposal. So there is, I believe, a method for good PSRO's to survive in this era.

Our proposal would be to turn the job of peer review over to our medicare contractors. We feel that this is a very cost-effective manner in which to do review. We feel that the contractors who are faced with these reviews need, in the everyday world of doing their private business, to have a significant amount of expertise in managing this review. We feel that they have the data processing skills to make review like this cost-effective, where focusing can occur.

We are already contributing through our contractor arrangements to their overhead, so there would be only incremental costs if they were to do the work. They are already performing certain types of medical review, the type of medical review that is not a medical necessity, but applies to contractual coverage. In other words, they must ascertain that surgery is not cosmetic, which is not even covered under the medicare program. So they would not be creating new medical review areas. They would merely be expanding on them.

We have developed a plan which is almost complete, which shows the ways that contractors can target and ways that we think they can be most effective in the review. However, we would be, if our plan were accepted, giving them a lot of latitude to do the process in the way that they feel was most effective. We would look more to the final, end review, as opposed to how it was done.

May I speak just a minute on the private sector? I think that we have occurring in the private sector some interesting things. There are coalitions springing up throughout the United States which are being started by business and labor. These coalitions are being joined by the provider associations. I think the key thing we need to consider here is that in this voluntary effort, which I tend to call voluntary effort No. 2, the focus and the pressures are coming not from the provider end, the provider end that might wish to avoid regulations, but from the private sector. If these coalitions and this pressure is successful, then it will help many of the plans we have before us.

Another thing that is happening in the private sector that could help our plan a little bit more is the pressures that are occurring right now on the private insurers. The private insurers are being asked by their purchasers: What are you doing to control health care costs? They are under pressures of losing business through self-insurance or of providing administrative services only if they do not come up with some explanation as to how they are contributing to the control of health care costs. So you see, they are in the same boat that we are in.

Mr. Chairman, while we support the approach in the President's budget, we are willing to continue to discuss with you and your committee ways that we can accomplish what we feel are our common goals with you. I will be pleased to answer any questions that you or the committee might have.

Senator **Durenberger**. Thank you. Let me start with a question that brings us up to date on what has happened since the Reconciliation Act was passed. You indicated that there is this weeding out process. That may not be the best terminology to use. What is your current evaluation of the effectiveness of the so-called remaining PSRO's and could you give us some idea of the mechanism, the assessment mechanism that you use or have been using, and what timetable you have for meeting the No. 1 reporting date?

Mr. **Thompson**. What was the last part of that, Senator?

Senator **Durenberger**. What timetable you have for meeting the September 1, 1982 reporting deadline that was built into the reconciliation.

Mr. **Thompson**. Senator, we expect to meet the reporting deadline, but I can provide you with some advance information now. We are now down to 147 PSRO's. The target, as set by Congress for us, was 130. We feel that the results of the 147 that we have right now are mixed. On the average, we feel that the results are still not up to the expectations of Congress or the administration. We feel that some of them have outstanding records, but that on the average they do not, and we still feel there needs to be a substantial change in the system.

Senator **Durenberger**. I am curious to know whether 130 or some other number was an appropriate number to use. What criteria are you using?

Mr. **Thompson**. We have very elaborate criteria, Senator, that we would be glad to submit for the record. We did not want to exceed the minimum that Congress had set, and actually we expected to drop closer to the 130 than we did. We now have 147 PSRO's which represent the elimination of 40 projects over the last year and a half. We are now reevaluating PSRO's as their grants come up for renewal to determine whether their results justify their continuance. As we continue our evaluations this fiscal year, we expect to be at or very close to the numerical target set by Congress. But I can submit the criteria we use for the record if you would like.

PSRO PERFORMANCE EVALUATION CRITERIA

Department of Health and Human Services
Health Care Financing Administration
Health Standards and Quality Bureau
Office of Professional Standards Review Organizations

February 16, 1982
(Revised as of April 12, 1982)

PSRO Code ____________
PSRO Name ____________
____

Page 1 - PSRO PERFORMANCE EVALUATION

	Met	Not Met	Point Value
I. Organization and Program Management			135
A. Administrative and Financial Management			50
1. Budget expenditures are maintained within negotiated limits; PSRO has not exceeded its overall budget levels (Note: Shifts between line items within Part I and shifts among Parts II, III, and IV are acceptable if within negotiated limits).	( )	( )	25

	Most Recent Cleared Audit (Other than close-out audit) (Period Audit Covered:____________)	Point Value
2. Check if applicable. Only items not checked will receive points.		
Audit findings indicate deficiencies in accounting systems and/or financial management. The criteria are applicable to audited deficiencies only. Findings are defined as:		(25)
a. Inability to provide source documentation (lack of audit trail supported by invoice, voucher, or other documentation).	( )	7
b. Inability to allocate costs, i.e. not only between Parts I and Parts II, III, and IV but also between Federal and Non-Federal sources/costs.	( )	7
c. Failure to obtain prior approval per PSRO policy requirement.	( )	4
d. Sustained dollar ($) findings exceeded 5% of awarded Part I costs found to be allowable.	( )	7

B. Cost Efficiency

1. Actual versus Negotiated Hospital Review Unit Cost (HRUC) Per Discharge

Actual HRUC per discharge should be calculated from quarterly reports covering the grant budget period most recently completed. Quarterly reports used by the ROs for cost efficiency calculations must have been received in the Regional Office by the date that the evaluations are due in the ROs.

If the most recently completed grant budget period was for a lesser or greater period than twelve months, please indicate this at the top of worksheet (a). If grant budget period was for nine months, fill in information for three quarters only and do calculation. If grant budget period was for fifteen or eighteen months add a line for quarter 5 and/or quarter 6 as appropriate and complete calculation.

- Follow directions in step "a" if all reports are available for the appropriate time period. Use worksheet (a) on page 2 for your calculations.
- Follow directions in step "b" if reports for the final quarter are not yet available for grant budget period. Use worksheet (b) on page 3 for your calculations.

All review costs, including MCE costs, must be included in the calculation. For example, all of Part II costs (CR and MCE) should be divided by nondelegated concurrent review admissions. All Part IV costs (CR and MCE) should be divided by delegated concurrent review admissions.

Please send copies of worksheets in as part of completed criteria sets.

Page 1B - PSRO PERFORMANCE EVALUATION

a. If all reports required are available:

- Determine the number of delegated and nondelegated hospital discharges from the HCFA 121s covering the applicable period. Assign partially delegated discharges as "delegated" if only the Review Coordinator (RC) function is delegated; assign to "nondelegated" if only the Physician Advisor (PA) function is delegated.

- Multiply the delegated discharges times the negotiated unit cost rate for delegated review that was included in the TE for the PSRO for the applicable period[1] to obtain delegated (Part IV) costs. (If funds were shifted to or from Part IV during the budget period, a new negotiated delegated unit cost rate must be calculated. This calculation should be shown at the bottom of worksheet (a).)

- Use only actual costs reported on the SF 269s that relate to the same time period of the HCFA 121s used above. Add amounts in row "b" of SF 269 (Total outlays this report period) column "f" (Total II and III) from the SF 269s to obtain Total Part II and III costs.

- Add Total Part II & III costs to Part IV costs, divide by total number of discharges to arrive at an actual overall hospital review unit cost rate for the PSRO area.

- Insert Negotiated HRUC per discharge for the applicable period and follow directions to obtain percent above or below negotiated HRUC.

b. If reports for the final quarter are not yet available, follow the general directions in step "a" and fill in the information that is available on worksheet (b). The remaining information will be filled in by Central Office and any further calculations will be completed at that time.

[1] This assumes the rate included in the TE accurately reflects the overall actual rate negotiated with the hospitals in the PSRO area. If not, a separate calculation must be completed to determine this rate.

PSRO Code ______ ___

Page 2 - PSRO PERFORMANCE EVALUATION

WORKSHEET (a)

Use for calculating unit cost when all quarterly reports are available for grant budget period being evaluated.

Number of Delegated Discharges ______________
Number of Nondelegated Discharges ______________
Total number of Discharges ______________

Negotiated Delegated Unit Cost Rate ______________
Times Delegated Discharges ______________

Part IV Costs ______________

Part II & III Costs:
Quarter 1 ______________
Quarter 2 ______________
Quarter 3 ______________
Quarter 4 ______________

Total Part II & III Costs ______________

Plus Part IV Costs ______________

Total Part II, III, & IV Costs ______________

Divided by total number of Discharges ______________

Equals Actual HRUC per Discharge ______________

Negotiated HRUC per Discharge ______________

If Negotiated HRUC is greater than actual HRUC:

Divide $\frac{\text{Actual HRUC}}{\text{Negotiated HRUC}}$ = __________. Subtract from 1.00 and multiply times 100 to obtain percent below negotiated unit cost. 1.00 - ____

If Actual HRUC is greater than negotiated HRUC:

Divide $\frac{\text{Negotiated HRUC}}{\text{Actual HRUC}}$ = __________. Subtract from 1.00 and multiply times 100 to obtain percent above negotiated unit cost. 1.00 - ____

PSRO Code ________

Page 3 - PSRO PERFORMANCE EVALUATION

Worksheet (b)

Use this worksheet when all quarterly reports are not yet available for grant budget period being evaluated. Fill in all information for those quarters available and also fill in the Negotiated Delegated Unit Cost Rate, Part II & III Costs and Negotiated HRUC. Central Office will complete the calculation.

	Column 1 Delegated Disharges	Column 2 Nondelegated Discharges	Column 3 Total QTR Discharges
QTR 1	________	________	________
QTR 2	________	________	________
QTR 3	________	________	________
QTR 4	________	________	________
Totals	________	________	________

Total of Column 1 = ________

Times Negotiated Delegated Unit Cost Rate ________

Total Part IV Costs $ ________

Add Part II & III Costs = ________

Total Part II, III & IV Costs = ________

Total Part II, III & IV Costs Divided by Column 3 Total Discharges $________ = $________ (Actual HRUC)

Negotiated HRUC = $ ________

PSRO Code ________

Page 4 - PSRO PERFORMANCE EVALUATION

B. Cost Efficiency

1. Actual versus Negotiated Hospital Review Unit Cost (HRUC) Per Discharge — 25

Indicate into which category the actual HRUC per discharge falls:

a.	Exceeded the negotiated HRUC by more than 1%	( )	-30
b.	Exceeded the negotiated HRUC by .6% up to 1%	( )	-15
c.	Exceeded the negotiated HRUC up to .59%	( )	- 5
d.	Met or was .59% below the HRUC	( )	5
e.	Was .6% to 1.59% below the HRUC	( )	10
f.	Was 1.6% to 2.59% below the HRUC	( )	15
g.	Was 2.6% to 3.59% below the HRUC	( )	20
h.	Was 3.6% or more below the HRUC	( )	25

2. Total Cost Per Discharge — 60

a. Obtain actual program management and support (PM&S) unit cost.

From the SF 269s applicable to the grant budget period add amounts in row b (Total outlays this report period) under columns (a) Program Management and (b) Program Support. Divide this total by total hospital discharges used in worksheet for B.1.

PM&S Costs

Quarter 1 ____________
Quarter 2 ____________
Quarter 3 ____________
Quarter 4 ____________

Total PM&S Costs ____________
÷ by Total Hospital Discharges ____________

PM&S Unit Cost________________

PSRO Code ____ ____

Page 5 - PSRO PERFORMANCE EVALUATION

b. Indicate Actual HRUC per discharge from B.1.

Actual HRUC per discharge______________

c. Add the PM&S Unit Cost and the Actual HRUC per Discharge to obtain actual total cost per discharge.

Actual total cost per discharge ____________

Indicate into which category the PSRO's total cost per discharge falls:

(1)	$17 or more	( )	-10
(2)	$16 to 16.99	( )	- 5
(3)	$15 to 15.99	( )	0
(4)	$14 to 14.99	( )	10
(5)	$13 to 13.99	( )	20
(6)	$12 to 12.99	( )	30
(7)	$11 to 11.99	( )	40
(8)	$10 to 10.99	( )	50
(9)	Under $10.00	( )	60

PSRO Code __________

Page 6 - PSRO PERFORMANCE EVALUATION

	Met	Not Met	Point Value
II. Performance of Review Operations - Compliance and Process			435
A. Acute Care Review			45
Indicators of acute care review process are:			
1. The review process is resulting in the issuance of at least 10 denials per 1000 discharges under review.	( )	( )	15
2. PSRO monitors a sample of Review Coordinator referrals and Physician Advisor decisions for appropriateness by reviewing original medical records on at least a yearly basis in all hospitals. There is documented evidence of problem correction as a result of this monitoring effort.	( )	( )	20
3. PSRO monitors samples of focused out cases to determine appropriateness of focusing decisions.	( )	( )	10
B. Special Actions to Address Identified Problems.			205
1. Modification of Review System.			75
(a) PSRO is addressing medical practice problems identified by MCEs/QRSs and utilization review through education (i.e. documented feedback, consultation or structured seminars) of practitioners or hospital staff with aberrant practice patterns.	( )	( )	15

PSRO Code ________

		Met	Not Met	
(b)	PSRO is addressing identified problems by performing preprocedure review.	( )	( )	10
(c)	PSRO is addressing identified problems by performing preadmission review other than preprocedure review.	( )	( )	15
(d)	PSRO has recommended rebuttal for individual cases or classes of cases or revocation of an institution's waiver of liability.	( )	( )	20
(e)	PSRO has "carved out" medically unnecessary days during a certified stay.*	( )	( )	15

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* **NOTE:** Carve out days are days denied as not medically necessary during an otherwise approved stay.

For purposes of this evaluation, item B.1.(e) can be marked "met" when days have been carved out even though waiver has not been revoked or rebutted.

Examples of carved out days are:

1. Unneccessary weekend admission.
   (The Review Coordinator reviews a patient's chart on Monday and finds that the patient was admitted on Friday to have elective surgery performed on Monday. Over the weekend no tests or treatments were performed; therefore, Saturday and Sunday are carved out (denied) days of the otherwise approved stay.)
2. Days of delay in scheduling diagnostic tests.
   (The Review Coordinator, performing concurrent review, certifies a patient's admission and assigns an initial continued stay review checkpoint of six days. When the case is again reviewed in six days, the Review Coordinator finds two days that are medically unnecessary because they were unnecessary days of delay in scheduling tests. Those two days are retrospectively carved out of the entire stay.)
3. Days of delay in receiving test results and days of delay in scheduling an operating room.

PSRO Code _ _ ____

Page 8 - SRO PERFORMANCE EVALUAT N

		Met	Not Met	
2.	Adverse Actions			130
(a)	PSRO has a defined set of procedures for dealing with actions potentially or actually sanctionable under Section 1160. The procedures include a decision-making process at the PSRO Board level.	( )	( )	10
(b)	PSRO can document that it provided a practitioner or institution with notice of aberrant practice which led to correction of the problem. Correction must be documented. (Notice of potential violation.)	( )	( )	40
(c)	PSRO can provide written documenation of a specific sanction warning letter to institution(s) and/or practitioner(s) issued in accordance with Section 1160 of the Social Security Act. (Notice of violation.)	( )	( )	40
(d)	PSRO has either resolved problem(s) after Section 1160 sanction warning or proceeded with sanction(s) recommendation(s).	( )	( )	40

PSRO Code _____.

Page 9 - PSRO PERFORMANCE EVALUATION

		Met	Not Met	
C.	Medical Care Evaluation Studies/Quality Review Studies			45
1.	PSRO has a method of assuring that, delegated and non-delegated, MCE/QR studies are based on written criteria and include thorough data analysis, peer review and complete documentation including restudy. The PSRO also has a method for tracking completion of MCE/QR studies.	( )	( )	20
2.	Complete the appropriate section of the following:			10
a.	PSRO meets at least 75% of the numerical requirement for MCEs as outlined in Transmittal No. 43 (Follow up studies cannot be counted as MCEs for this purpose. See Section D, V, pg. 6, Transmittal 43). No. Required ______ No. Completed ______	( )	( )	
	or			
b.	PSRO completed at least the minimum number of studies as outlined in Transmittal No. 100 if the PSRO has had an approved alternative review plan. No. Required ______ No. Completed ______	( )	( )	
	or			
c.	PSRO completed the number approved by the Project Officer under other waiver provisions. No. required _______ No. completed_____	( )	( )	
3.	An evaluation of each delegated hospital's quality review program (procedures, responsible staff and committee, etc.) was performed by the PSRO at least once to determine if the hospital is organized to conduct and is conducting meaningful studies/PSRO evaluated its Quality Review Program in hospitals non-delegated for MCE/QR studies at least once to determine if the hospital is organized to conduct and is conducting meaningful studies.	( )	( )	15

PSRO Code ________

		Met	Not Met	
D.	**Data System**			50
1.	PSRO PHDDS data covering 90% of Federal discharges under review for the 12 month period prior to the last quarter of the most recently completed grant with an error rate of not more than 2% has been received by Central Office, HSQB by 60 days following the end of the quarter. (This criterion will be marked in Central Office.)	( )	( )	15
2.	PSRO has monitoring system to assure quality and accuracy of data collected and mechanisms for corrective action. This system includes re-abstracting studies at least once a year for each facility and provides for corrective measures to be implemented when significant errors are found.	( )	( )	15
3.	The PSRO data system provides batch reports which facilitate the identification of potential utilization problems by hospital, diagnosis and physician at least twice a year in at least two different quarters and provides the ability to follow up inquiries in an interactive mode.	( )	( )	20

PSRO Code ___ ___

	Met	Not Met	
E. Profiles*			90
1. PSRO produced profiles twice in at least two different quarters which have the following characteristics:			
a) Profiles identify and specify potential problems, by institution, practitioner, and/or diagnosis.	( )	( )	5
b) Profiles drawing comparisons among hospitals and among physicians are case-mix adjusted.**	( )	( )	20
2. PSRO collected at least twice either routinely or in special studies, additional data elements on its hospital abstract to facilitate problem identification, objective setting, and/or impact assessment. Mere routine collection of more data elements than the minimum PHDDS abstract does not meet this criteria.	( )	( )	10
3. PSRO presented profiles on individual and relative hospital performance to its hospitals at least every six months. These profiles should reflect the hospital's performance on 50% or more of its Federal caseload. The PSRO works with the hospitals to use profile data to verify and specify problems, and assists hospitals in developing action plans to correct problems.	( )	( )	30
4. Twice a year in at least two separate quarters PSRO generated profiles on all physicians, PSRO-wide, to identify problem physicians. PSRO provided these profiles individually to problem physicians.	( )	( )	25

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* Profiles are defined in 42 CFR 466.2 as:

"aggregated data in formats that display patterns of health care services over a defined period of time."

** Case-mix adjustment is a statistical adjustment procedure that allows a single utilization figure (such as ALOS) for a physician or hospital to be meaningfully compared to other physicians or hospitals even though they may be treating patients with a different diagnostic mix.

PSRO Code ____________

Page 12 - PSRO PERFORMANCE EVALUATION

III. Performance of Review - Impact/Potential Impact 1200

A. Management of Objectives 150

-Documentation for items 1, 2, 3, 7, 8 and 9 should be based on the most recently awarded grant (current year) for all PSROs. Documentation for items 4, 5 and 6 should be based on the same time period used for III B. - G.

1. PSRO had a minimum of 4 objectives which met all of the following criteria: (Use worksheet provided on page 13 for documenting this item.) ( ) 50
   - a. reflected significant problems in utilization or health implications in the PSRO area (adequate depth);
   - b. based on data;
   - c. based on validated problems;
   - d. were measurable with appropriate baselines and targets;
   - e. included well-defined methodologies;
   - f. were monitorable by activity or impact data on at least a quarterly basis by the PSRO;
   - g. had specific timeframes for interventions and intended outcomes;
   - h. in the aggregate, affected a major segment (at least 5%, subject to specific review based on objectives) of the PSRO population subject to review (adequate breadth).
2. PSRO had at least one quality objective; or, ( ) 5

   PSRO had more than one quality objective. ( ) 10
3. PSRO submitted objectives as prescribed in Chapter IV of the Grant Application and Instructions. ( ) 5

Check ( ) the one statement which best describes the objectives in each of the following items:

4. Documentation supports the fact that the PSRO followed-through with the proposed implementation of the approved objectives, (as modified, if appropriate):

(a) No follow through	( )	0
(b) For less than a majority	( )	5
(c) For a majority of objectives	( )	10
(d) For all objectives	( )	20

PSRO Code ________

Worksheet for III.A.1

	1.	2.	3.	4.	5.	6.	7.
Objective number (Provide key on separate sheet)	Impact or Quality Obj. (Mark I or Q)	National priority/ known priority problems addressed. (Mark with X)	Baseline and goal rates are measurable with data source and time periods identified for both (Mark with X)	Intervention is appropriate and its scope is consistent with the goals. (Mark with X)	Milestones included. Monitorable by PSRO quarterly (Mark with X)	Problem Validated (Mark with X)	Potentially will collectively affect at least 5% of PSRO area discharges (List estimated number affected below)

* Minimum of 4 objectives must meet all of the criteria (columns 1 through 6) above, and collectively meet the last criterion

Total affected: ________

Objectives acceptable ________ not acceptable ____________ (insert number)

Project Officer: ____________________ Date: __________

% of area total: ________

Total No. of Discharges 1981 ________

5. Objectives were adequately developed prior to submission so that after they were submitted the PSRO did not discount objectives as not an actual problem (e.g. situation justified).

(a) No objectives adequately developed	( )	0
(b) Less than a majority adequately developed	( )	5
(c) A majority of objectives adequately developed	( )	10
(d) All objectives adequately developed	( )	20

6. PSRO objectives were developed adequately prior to submission in that they did not require extensive modifications (such as changes in timeframes greater than 30 days, changes in baseline or target descriptors, development of alternate interventions) subsequent to submission, when these changes should have been anticipated at the time the PSRO submitted the original objective.

(a) No objectives adequately developed	( )	0
(b) Less than a majority adequately developed	( )	5
(c) A majority of objectives adequately developed	( )	10
(d) All objectives adequately developed	( )	20

7. The objectives as submitted by the PSRO and approved by the Project Officer included alternative methodologies to assure success.

(a) No objectives	( )	0
(b) Less than a majority	( )	2
(c) A majority of objectives	( )	3
(d) All objectives	( )	5

8. The approved objectives, as described in the grant application format, reflected extensive developmental work prior to their proposal. Such developmental work includes the conduct of special MCEs/QRSs or surveys, or the analysis of specially developed profiles or data reports.

(a) No objectives	( )	0
(b) Less than a majority	( )	5
(c) A majority of objectives	( )	8
(d) All objectives	( )	10

9. For the utilization objectives approved in this period the PSRO, if it accomplishes the objectives as accepted, will achieve the following fraction of days saved. (Express as decimal to four places using 1) the formula described in the impact utilization section and 2) the worksheet provided on page 15 immediately following this section.) Check appropriate box:

a. 0.0050 or Less	( )	0
b. Greater than 0.0050 but less than or equal to 0.0100	( )	2
c. Greater than 0.0100 but less than or equal to 0.0150	( )	3
d. Greater than 0.0150 but less than or equal to 0.0200	( )	4
e. Greater than 0.0200 but less than or equal to 0.0250	( )	5
f. Greater than 0.0250 but less than or equal to 0.0300	( )	6
g. Greater than 0.0300 but less than or equal to 0.0350	( )	7
h. Greater than 0.0350 but less than or equal to 0.0400	( )	8
i. Greater than 0.0400 but less than 0.0500	( )	9
j. Greater than 0.0500	( )	10

PSRO Code________

Projected Utilization Impact Chart (Item III A.9)

	Baseline Period		Impact Period					
Objective Number (Provide Key on Separate Sheet)	(1) Number of Discharges	(2) ALOS	(3a) Anticipated Number of Discharges	(3b) Fractional Change-	(3c) Adjusted Number of Discharges (3a- 3ax3b)	(4) ALOS	(5) Anticipated Days Saved ALOS (col 1 x [col 2 -col 4])	(6) Anticipated Days Saved Admissions ([col 1 - col 3c] x col 2)
						Total	(5a)	(6a)

(7) Total projected days saved (Total box 5a + Total box 6a) = ________

(8) Total Medicare hospital days in FY 81 (from HCFA 121) = ________

(9) Fraction of projected hospital days saved by PSRO objectives (Express as decimal to 4 places) (Box 7 ÷ Box 8) = ________

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B. Impact on Utilization 650

1. Based on Utilization Objectives 500

Chart (see specific instructions following and document on chart provided on page 16) is to be completed and carefully validated for accuracy by the Project Officer. The Project Officer validation will be to assure that the information supplied by the PSRO meets the following:

a. The PSRO has data documentation to support the impact claimed for each objective listed on the chart.

b. The objectives listed on the chart are listed on an attached key.

c. The PSRO has reported impact (or nonimpact) on all objectives which it had pursued in the reporting period.

d. The PSRO has described the objective and the related impact as it had been previously submitted and/or subsequently formally modified.

e. The arithmetic and calculations are correct.

Timeframe - Documentation must be based on the most recently completed grant budget period except for the PSROs listed on pages i amd ii of instructions. That listing contains specific time periods to be covered for Section III.

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PSRO Code_ ________

Utilization Impact Chart - Item III B

Objective Number (Provide Key on Separate Sheet)	Baseline Period		Impact Period			(4)	(5) Actual Days Saved ALOS (col 1 x [col 2 -col 4])	(6) Actual Days Saved Admissions ([col 1 - col 3c] x col 2)
	(1) Number of Discharges	(2) ALOS	(3a) Actual Number of Discharges	(3b) Fractional Change	(3c) Adjusted Number of Discharges (3a- [3ax3b])	ALOS		
						Total	(5a)	(6a)

(7) Total days saved (Total box 5a + Total box 6a) = ________

(8) Total hospital days used (from HCFA 121) = ________

(9) Fraction of projected hospital days saved by PSRO objectives (Express as decimal to 4 places) (Box 7 ÷ Box 8) = ________

Instructions for Completing the Utilization Impact Chart

General Instructions

1. Impact must be measured against the objective as stated. Utilization impact must be measured precisely as the PSRO set the objective in the grant application or as the objective was formally added or modified by the PSRO and agreed to by the Project Officer. Thus, the impact on utilization reported in this section must be measured exactly in the way each objective was formulated and, furthermore, only impact that can be linked to a specific objective can be counted. Objectives to be counted are the last set agreed upon between the PSRO and the Project Officer reflecting all modifications that have been made over the course of the grant period.

2. List all objectives. All utilization objectives must be listed on the chart and include all impact information. Objectives which were not achieved should report the actual negative impact despite the fact that under most situations, as described later in these instructions, the impact will be computed as a zero (0). Objectives for which the PSRO has no data by the due date of the evaluation will also be rated as zero (0).

3. Provide a key of objectives. A key or list must be provided to accompany the chart which gives the objective statement for each objective listed on the chart as well as the primary intervention utilized by the PSRO.

4. Only approved objectives may be considered. Only impact related to specifically stated and agreed upon objectives can be included. Impact linked to other PSRO activities such as focused review or sanctions can not be counted in this section if it is not specifically part of the proposed outcome of a stated PSRO objective.

5. Reduced certified days = saved days. Reduction in the number of certified days can be computed as saved days even if the actual length of stay was not reduced. This means that all days certified for payment at any level of care must be included.

6. Double-counting. Frequently two or more utilization objectives will include at least some of the same hospital stays. If impact is simply calculated for each of these separately, making no correction for the overlap, some of the impact will be double-counted. Examples of overlapping objectives which could lead to double-counting of impact would include:

   a. Separate objectives dealing with pre-operative length-of-stay and with average length-of-stay for the same procedure(s).

b. An objective dealing with a group of specific diagnostically related groups (DRGs) and another objective dealing with a group of procedures where the DRGs and procedures may partially overlap.

c. Separate objectives dealing with specific diagnostic groups, hospitals, and/or physicians which may overlap to some degree.

d. A general objective claiming credit for an overall reduction in average length-of-stay for all Medicare patients and objectives relating to specific diagnoses, hospital, or physician reductions for these same patients.

In order to eliminate double-counting of impact, the degree of overlap among objectives should be determined and measures of impact should be corrected accordingly. PSROs should readily be able to determine the hospital stays which are covered by more than one objective from their PHDDS data.

For example, if a PSRO has an objective to reduce Medicare average length-of-stay at Hospital A and another objective to reduce average length-of-stay of DRG B across all hospitals, in determining impact, the impact for DRG B across all hospitals would have to be determined to calculate the impact for Hospital A after eliminating the stays for DRG B at Hospital A. That is, the impact for Hospital A is calculated by determining the difference between baseline and impact period average length-of-stay for all Medicare discharges, other than those in DRG B, and then multiplying the difference times the number of Medicare discharges in the baseline period after subtracting out the number of discharges in DRG B. The impact of reducing the average length-of stay for DRG B at Hospital A therefore would be counted only once.

If impact is claimed for a broad general objective, such as reducing overall average length-of-stay for all Medicare patients, impact cannot be claimed for any other average length-of-stay objective dealing with Medicare stays.

7. Zeroing-out negative impact. If a PSRO sets an objective dealing with a particular diagnosis or procedure group in a number of hospitals and the net impact for this objective is negative, the entire objective may be zeroed out. If the PSRO sets a number of separate objectives each dealing with a different diagnosis group, each in a number of hospitals, and some of the objectives on the diagnosis group show net negative impact, these may be zeroed out. However, within each diagnosis objective, net impact is determined by adding both positive and negative impact for individual hospitals. Net impact may also be determined by

considering the discharges for the diagnosis group for all hospitals involved together in one calculation of impact. When the objective deals with several diagnosis groups at a number of hospitals, it is not allowable to zero-out negative impact for one of the diagnosis groups at a specific hospital.

Similarly, if a PSRO sets an objective to reduce average length-of-stay at one or more hospitals for a number of specific diagnoses and if the net impact for a hospital is negative, it may be zeroed-out and not counted against positive impact achieved at other hospitals. The net impact for a hospital is determined by adding both positive and negative impact for all diagnosis groups included in the objective at the specific hospital. It is not allowable to zero-out negative impact for a specific diagnosis group at an individual hospital.

8. Weekend admissions; Sunday/Monday discharges. The impact due to reducing weekend admissions is appropriately calculated by multiplying the number of reduced admissions by the difference in average length-of-stay between weekend admissions (Friday or Saturday) and all other admissions. If data is not available to determine this difference in average length-of-stay, it may be estimated by assuming a difference of 1.5 days. That is two (2) days additional for a Friday admission and 1 (one) day for a Saturday admission for an average of an additional 1.5 days. It is incorrect to multiply the number of reduced admissions by the total average length-of-stay for these admissions. The same reasoning and calculation system should be used for reducing Sunday/Monday discharges. (Since this is an admissions objective, the number of discharges in the impact period should be adjusted.)

9. Emergency admissions. Many PSROs have reduced the number of emergency admissions, but it is not clear that these patients do not become regularly scheduled admissions. It would, therefore, not be permissible to allow PSROs to claim the reduced number of admissions times the total length-of-stay. Depending on how the PSRO actually structured its objective, there are two different manners for calculating impact for reducing emergency room admissions:

    a. If the PSRO reduced emergency admissions by upgrading the capabilities of the emergency room to handle some cases strictly on an outpatient basis, then the PSRO may take credit for these cases. For example, if the emergency room laboratory facilities are improved so that patients do not have to be admitted for certain X-rays, then the PSRO can claim the baseline average length-of-stay for those cases. (Since this is an admissions objective, the number of cases in the impact period should be adjusted for changes in the eligible population.)

b. If the PSRO merely has stopped abuses in admitting patients via the emergency room then the PSRO may claim the reduced number of admissions times the difference between the average length-of-stay for emergency admissions and regularly scheduled admissions. These figures must be calculated and supported by documentation; no estimate of the savings can be allowed. (Since this is not really an admissions objective, the number of discharges in the impact period would not be adjusted.)

10. Reductions in one and two-day stays. To calculate the impact due to a reduction in one (1) and two (2) day admissions is to simply multiply the amount by which the number of two-day stays were reduced by two and to multiply the amount by which the number of one-day stays was reduced by one. (Since this is an admission objective, the amount should be adjusted to account for changes in the eligible population.)

11. Calculating impact for objectives to reduce admissions or to reduce the total days of care per 1000 rate. In order to calculate the number of days saved due to an objective designed to reduce admissions, it is necessary to determine the difference between the number of admissions in the baseline period and the number of admissions that would have occurred in the impact period had the population-at-risk (i.e., the Federal beneficiary population) remained unchanged. Thus, in calculating the impact due to objectives designed to reduce admissions, the number of admissions in the impact period should be adjusted for the percentage increase or decrease in the Federal enrolled population.

For example, assume that the objective was to reduce admissions in Calendar Year 1981, and therefore, the baseline period is Calendar Year 1980. If the Medicare population increased by five (5) percent, the number of Medicare admissions covered by the objective in the impact period should be reduced by five (5) percent before the comparison of baseline to impact is made.

In order to determine the approximate changes in the Medicare beneficiary population from baseline to impact period, the following method should be used:

Consult the table entitled "Medicare Enrollment For Hospital Insurance (Part A) Age 65 and Over, By PSRO Area". The right hand side of this table shows the annual, year-to-year changes in the enrolled Aged Medicare population for the period 1974-1980. Compute the average percent year-to-year change in the last two (2) years available, 1978-1979 and 1979-1980. This percent change, with the opposite sign, should then be applied to the number of admissions in the impact period before comparing the number of admissions to the number in the baseline period.

Most PSRO objectives will have a baseline and impact period which span 1980-1981. One would calculate the estimated population change by averaging the changes from 1978-79 (A) and 1979-80 (B) or $\frac{(A + B)}{2}$

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If an objective to reduce admissions affects both Medicare and Medicaid populations, the two population groups must be reported separately. The adjustment described above applies only to Medicare, as the Medicare and the Medicaid population changes are usually not the same. In fact, our information shows that for most areas there are not significant changes in Medicaid eligibles. If the PSRO can provide reliable data reflecting changes in the Medicaid population between the impact and baseline periods, this data can be used. Otherwise assume that the Medicaid population has not changed from the baseline to impact period.

If an objective is stated as a reduction in an admission rate, it is necessary to determine the number of actual admissions in the baseline and impact periods and then to use the method described above to adjust for population changes, in order to obtain the number of days saved.

If an objective is stated in terms of reducing the Total Days of Care per 1000 rate, the number of days saved should be determined using a method analogous to that for reducing admission rates. That is, first determine the number of actual days used in the baseline and impact periods. Adjust the number of days in the impact period for any change in population as you would for admissions. Then, simply subtract the adjusted number of days in the impact period from the number of days in the baseline period to determine the number of days saved. On the chart, the same columns used for admissions should be used for total days of care objectives.

12. Total number of hospital days used in baseline period. The data on total number of hospital days used by Federal beneficiaries during the baseline period should be obtained by adding the figures in columns 11, 13, 15, and 16 on the PSRO 121 forms covered by the baseline period. Please verify the figures against the 121s and be sure that these figures are consistent with figures reported by the PSRO for other time periods. PSROs may adjust this data for periods of time of less than one quarter if they can provide documentation for these figures to the Project Officer.

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The Utilization Impact Chart

General Definitions for Utilization Impact Chart

Baseline Period - The immediate past corresponding period to the impact period. Usually this is the previous 12-month grant period. It is important that the months used for the baseline period usually be the same as the months in the impact period to allow comparability both in length of time and seasonality. No less than a 3-month (one quarter) timeframe for baseline is acceptable for utilization objectives.

Impact Period - The most recently completed grant budget period except for the PSROs listed on pages i and ii of the instructions. That listing contains specific time periods to be covered for Section III.

Total Days Saved- The sum of days saved by reducing average certified length of stay and days saved by reducing admissions.

Special Instructions:

A. The chart may be reproduced and additional pages may be used as necessary.

B. When zeroing-out, please indicate actual negative figure and draw a line through that number (without obliterating) and place a "0" next to it.
Example: -175 0

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Columnar Definitions and Instructions:

Objective Number - Assign each objective a unique identifier. Provide a key on a separate sheet of paper. See General Instruction number 2.

Column 1 - Number of discharges covered by objective in the baseline period.

Column 2 - Average Length of Stay for discharges covered during the baseline.

Column 3 - (a) Actual number of discharges covered by the objective in the impact year.

(b) Fractional change in enrollment computed by dividing by 100 the percentage change taken from the table entitled "Medicare Enrollment for Hospital Insurance." See General Instruction number 11.

(c) Adjusted number of discharges in the impact period, or Column 3(a) - Column 3(a) X Column 3(b) . Note: Column 3(a) X Column 3(b) may be a negative figure. If this figure is negative it is then added to 3(a). Conversely, if this figure is positive it is subtracted from 3(a).

Column 4 - Average Length of Stay for discharges covered by objective during the entire impact period. (Not just the final quarter).

If the purpose of the objective is to reduce unnecessary admissions skip Column 5. If the purpose of the objective is to reduce average length of stay (or pre- or post-operative length of stay), continue with Column 5.

Column 5 - If average length of stay decreased, calculate the number of days saved by multiplying the number of discharges covered by the objective in the baseline period by the reduction in ALOS, or Number of days saved = (Column 1) X (Column 2 - Column 4). If average length of stay increased enter zero (0) for number of days saved. (See Special Instruction B.)

Column 6 - For objective to reduce unnecessary admissions, if the number of admissions in Column 3(c) decreased from the baseline period, calculate the number of days saved as follows: (Number of discharges during baseline period minus Number of Adjusted discharges during impact period) X (Average Length of Stay during the baseline period), or Number of days saved = Column 1 - Column 3(c) X Column 2 . If the number of admissions increased enter zero (0) for number of days saved. (See Special Instruction B.)

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Box 7 - Total days saved in each year by PSRO objective-specific activity, or the sum of Column 5 + the sum of Column 6.

Box 8 - Total number of hospital days used by Federal Beneficiaries in PSRO area during baseline period (From HCFA 121, sum of Columns 11, 13, 15 and 16 for all quarters included in the baseline period.)

Box 9 - Fraction (rounded to 4 decimal places) of all hospital days saved by PSRO objectives, or Box 7 divided by Box 8. Do not express as percentage.

2. Based on National Medicare Days of Care — 100

The scoring of this section will be accomplished by computing changes in total Days of Care/1000 (TDOC/1000) Aged Medicare enrollees in relation to change in other areas, using 1980 as change year. Data will be migration adjusted. The information on each PSRO will be arrayed and points assigned based on distribution of changes in TDOC. Where a PSRO was not implemented or data is not available an adjustment score will be derived. (Central Office will complete this section.)

	Met	Not Met	
3. Based on Ancillary Services Review Objectives			50
a. PSRO set ancillary services review objective(s) which were approved by the Regional Office. (Applicable to current grant year objectives.)	( )	( )	10
b. PSRO reduced inappropriate utilization of specific ancillary service. This impact is related to predetermined approved objective(s). (Applicable to completed objectives from previous grant year.)	( )	( )	40

C. Impact On Quality — 400

Quality impact is defined as resolution of important patient care problems. The key elements in problem resolution are, therefore, the degree to which the problem is solved, the severity of the problem, and the number of patients affected.

Instructions for Completing the Quality Impact Chart

General Instructions

1. Documentation must be based on comparable data. Data sources include (but are not limited to) PSRO data, hospital data, special surveys, PHDDS and MCE/QRS reports. Impact is measured in most recent completed grant budget period except for the PSROs listed on pages i and ii of the instructions. That listing contains specific time periods to be covered for Section III.

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2. Credit will be given only for resolution of problems identified by the PSRO in an impact objective or an acceptable MCE or Quality Review Study. An acceptable MCE or Quality Review Study is one in which:

   - the PSRO or delegated hospital has identified a patient care problem, and
   - intervention occurred in the impact period and has been documented; and
   - followup has been completed to assess change in the problem; and
   - if from a delegated hospital, the PSRO has accepted the MCE or quality review study.

3. The amount of credit will depend on:

   a. The degree of problem resolution.

      The degree of problem resolution is defined as the actual reduction in a problem (measured in discharges affected) adjusted to the rate of occurrence of that problem during the baseline period (also measured in discharges).

   b. The degree of adverse effect of the problem on patient care and patient care outcome.

      The degree of adverse effect in the following categories of medical significance describes actual adverse effect on patient well-being, not possible outcomes.

      (1) Life threatening is defined as significantly higher patient mortality than would be expected given professionally recognized standards of patient risk.

      (2) Major loss of function is defined as actual permanent limitation or loss of significant physical capability resulting from unnecessary surgery or inappropriate medical care. Examples are:

         - amputation of healthy limb
         - neurologic deficits

         :

- hysterectomy (for example, removal of healthy uteri in women of childbearing age.)

(3) Other adverse effects are defined as actual inappropriate outcomes of medical care which do not result in death or permanent loss of function(s). This category includes complications (including iatrogenic illness) and/or unnecessarily prolonged recovery time that occur (and are documented through application of criteria) because of inappropriate surgery, medical care, or the lack of appropriate care.

Examples are:

- inappropriate drug therapy which did not result in death or permanent loss of function
- repeat diagnostic procedures due to poor patient preparation
- infection control problems not resulting in death or permanent loss of function.

(4) Other patient care quality problems are defined as practices which may reflect or result in inappropriate patient care outcomes. Examples are:

- documentation problems
- potential patient harm
- patient discomfort

c. The relationship of the PSRO's achievements (measured by "a" and "b", above) to all inpatient care under PSRO review (as measured by total PSRO discharges). This will be computed by dividing the sum of all reduction in identified problems (weighted by the adverse effect of each problem) by the total discharges subject to PSRO review in the Baseline period. (See example at end.)

General Definitions

1. Baseline Period - The immediate past corresponding period to the impact period or the period in which the baseline data was generated. In no case may the baseline period be more than 24 months prior to the impact period.

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Where impact period is less than 12 months, it is important that the same months be used for the baseline period.

2. Impact Period - Usually the grant period, but as short as 3 months where consistent with the objective.

Special Instructions

1. The chart may be reproduced or additional pages may be used as necessary.

2. When actual change is opposite to that specified in the impact objective, please indicate actual (negative) figure and draw a line through that number (without obliterating) and place a "0" next to it. Example ~~-175~~ 0.

Columnar Definitions and Instructions:

Objective Number - Assign each objective or study a unique identifier. Provide a key on a separate sheet of paper. (Also see Columns 1, 2, 3 and 4 below.)

Column 1 - Total number of cases in the baseline period covered by the approved objective or MCEs or Quality Review Studies. This number represents total discharges appropriate to the objective. Examples are one physician's cases, the medical discharges from a hospital, the total discharges with a specific procedure, etc. Documentation that allows verification of total discharges appropriate to the objective must be included in the key.

Column 2 - Number of cases with problem. Alternatively, it may be an MCE sample, the total cases multiplied by the proportion of sampled cases with unjustified variations. The basis (MCE or Special Study, Full Count or sample, etc.) and documentation for column 2 should be included in the key.

Column 3 - Total number of cases covered by the objective in the impact period. Specify documentation in key.

Column 4 - Number of cases with problem covered by the objective in the impact period as documented by the PSRO. Specify documentation in key.

Column 5 - Rate at which problem occurs in impact period. (Column 4 ÷ column 3 rounded to three (3) decimal places).

Column 6 - Rate at which problem occurs in impact period applied to total cases in baseline period. (Column 5 X column 1, rounded to one (1) decimal place).

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Column 7 - Adjusted reduction in cases with problem (column 2 - column 6). If number of cases increased enter zero (0). (See Special Instruction 2.)

Columns 8(a) to (f) - Scoring scale applied on basis of criteria listed under III.C.3. This will be completed in CO.

(a) Objective number as used in first column of chart

(b) Same as column 7

*(c) Factor applied by OPSRO

(d) Reduction in cases weighted by factor. (Column b x column c).

(e) Total number of Federal discharges subject to PSRO review in PSRO area during baseline period from the HCFA 121. If the baseline period covers more than one year, use the average of the two one-year periods.

(f) Fraction of discharges affected by the PSRO quality objectives and MCE/QRSs.

*Weights assigned to the adverse effect categories (defined on pages 17A and 17B for use in Column 8(c) on page 18) are as follows:

(1) Life threatening.....................10

(2) Major loss of function...............07

(3) Other adverse effects................03

(4) Other patient care
quality problems.....................01

Objectives or studies presented which do not demonstrate quality impact or which fail to document PSRO validation of the problem and intervention will receive "0" weight.

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Quality Impact Chart

Objective Number or MCE/QRS Number (Provide Key on Separate Sheet)	Baseline Period		Impact Period				
	(1) Total Cases	(2) Cases With Problem	(3) Total Cases	(4) Cases With Problem	(5) Rate for Problem (col 4 ÷ col 3)	(6) Impact Adjustment Factor (col 5 X (col 1)	(7) Adjusted Case Reduction in Problem (col 2 - col 6)

Do Not Write Below This Line

(8) Weighting for Problem's Adverse Effect:

(a) Objective, MCE, QRS Number	(b) Adjusted Reduction (col 7)	(c) Adverse Effect Factor	(d) Weighted Reduction (col b X col c)
			Total

(e) Total Discharges Subject to PSRO Review (from HCFA 121) ________

(f) Fraction of Discharges Impacted (Express as decimal to 4 places) Total of col. 8d ÷ 8e ________

Score ________

Senator DURENBERGER. All right. That might be helpful to us if you did.

If we move ahead with the peer review, using the contract mechanism, could you give us some idea of how quickly HCFA could be ready and able to carry out this system?

Mr. THOMPSON. That is a difficult question to answer, Senator, because I think that we would need to spend time with your staff and the committee to further clarify some of the aspects of your bill. I am unable to put a timetable on it, not knowing all the details of exactly how each aspect of the contracting would occur.

Senator DURENBERGER. Well, sticking with the contractor notion, I guess I still feel very strongly about the need for peer involvement in the review process. Could you share with us some ideas of how you would propose to involve physicians if you rely on contractors?

Mr. THOMPSON. I worked for many years in the contractor field, and I can give you a little background of how we, at the plant I worked at, operated. We felt that our physician review had to be done by physicians that were acceptable in the community. Therefore, we never hired a full-time physician. It had to be a practicing physician.

We also hired physicians that were recommended by the local medical society. Therefore, the physicians, when they made decisions, could deal in a peer form with the community because in the whole process of review, there is a lot of educational activities that need to occur and exchange of information between doctors as to what a reasonable level is.

Contractors realize that if they are to be involved in this educational activity, they must have physicians who are acceptable to their peers. And I think that that generally applies to most contractors.

Senator DURENBERGER. So you favor it and you suggest that the process that you have outlined today is the best way to go about involving peers?

Mr. THOMPSON. The emphasis that the private carriers need to put on their own business, the fact that we can jointly work with them on targeting and they have data from both the private and the Government side within their shops to review, the fact that it is very cost-effective, the fact that it is relatively easy to get started—we find that there are many attractive things in our recommendation.

Senator DURENBERGER. The last question I will ask you is about attractiveness, or to put it another way, incentives. In a medicare contractor system, what would be the direct incentives for contractors to perform well?

Mr. THOMPSON. Contractors, in recent years, are being evaluated very stringently on many aspects of their operation. We have the authority to drop poor contractors. The contractors realize this. Every year we make a cut of our poorest performing contractors and work with them in a corrective manner or put them on notice that they are subject to being dropped from the program.

Rather than contracting, this is, to a degree, negotiating but it has been very effective. We have reduced the number of contractors last year by 15 or 20, something like that. I do not have the exact figure. And we find that the contractors are responding to the directions we are giving them.

Senator **Durenberger**. That sounds like a disincentive. Are there any incentives?

Mr. **Thompson**. Well, the incentive is that they are very deeply involved in the health care world. They want, both from an idealistic standpoint and a practical standpoint, to remain involved in the medicare program, and it covers some of their fixed overhead. It has some little advantage to it.

Senator **Durenberger**. Primarily it is idealism and secondarily economics?

Mr. **Thompson**. I am not sure in a given plan which one you would put first.

Senator **Durenberger**. You cannot be any more specific on the economic incentives?

Mr. **Thompson**. More volume in an organization can many times be added with only incremental costs, and you are able to spread your overhead costs over a larger base. This is a real economic incentive: the ability to work jointly with medicare to deal with medical utilization review. It helps strengthen their hand. They become more prestigious in the business community because they are not only in the private sector but they are in the Government sector. There are lots of small, intangible things, Senator, besides the idealism, that causes them to want to be in the program.

Senator **Durenberger**. Senator Baucus.

Senator **Baucus**. Thank you.

Mr. Thompson, in your prepared statement you say that "Contractors would be allowed to design their own program of review in that effective PSRO's could sell their services to the fiscal intermediaries."

My question is whether intermediaries could afford to pay for the services of PSRO's, since they are being level-funded, and also because as a practical matter, intermediaries would have to give up audit dollars because of level funding and due to inflation would have to cut back on auditors. And that frees up money to pay for the services.

As a practical matter, could they afford to pay for those services?

Mr. **Thompson**. It would depend on how cost-effective they were, Senator.

Senator **Baucus**. But what evidence do you have that they are not sufficiently cost-effective today so that they could be more cost-effective to do the job? What evidence do you have of that?

Mr. **Thompson**. Would you repeat that?

Senator **Baucus**. Implicit in your answer was that they are not presently cost-effective.

Mr. **Thompson**. Oh no, quite the contrary. I think that there are some that are.

Senator **Baucus**. Where are they going to pay for these PSRO services, then, if they have to cut out auditors as a practical matter?

Mr. **Thompson**. That we would leave up to our contractors as to whether they felt that the best way they could deliver the responsibilities that we lay on them would come through their own review mechanism. You see, currently, there are some private insurers that are contracting with PSRO's. They have, in essence, found this to be a cost-effective way to go.

Senator BAUCUS. Is it your understanding, though, that intermediaries would continue to be level-funded?

Mr. THOMPSON. The intermediaries would what?

Senator BAUCUS. Continue to be level-funded, that is for their administrative services?

Mr. THOMPSON. We are constantly reviewing the funding of their intermediaries. We have underway right now a rereview of all contractor instructions which have built up over the years since the program was started. We hope to develop some economies out of this review. If economies can be achieved, we would probably wish to put them in the medical review side of the program.

Senator BAUCUS. As I understand what you are saying, it is essentially that you want to eliminate, or at least drastically change PSRO's because they are not saving health care dollars. That is, they are not cost-effective. Is that right? Is that what you are saying? Is that the bottom line here?

Mr. THOMPSON. The bottom line is that there have been many estimates as to how much overutilization there is in the health care world. A conservative estimate is that as much as 10 percent.

Senator BAUCUS. You want to return to pre-1972 and have the intermediaries perform this service?

Mr. THOMPSON. Pre-1972 was a different world. The pressures in pre-1972 were very different than they are now.

Senator BAUCUS. Would you describe those differences? What are they? If we were not saving enough dollars in 1972, which prompted PSRO's in 1972, what has changed so that now in 1982, in turning back to pre-1972, we are going to get more savings than we achieved in the last 10 years? What has changed so that you think there will be a significant increase in savings?

Mr. THOMPSON. During that period of time I actually worked in a hospital as a finance director. I have seen some of the interactions that have occurred.

Prior to 1972, there were pressures. There were enough pressures to cause the PSRO legislation to be formed, but they were significantly different than they are now. As you know, our pressures are much greater now than they were then.

In the private sector, for example, the industry had been willing to go through a series of annual premium increases without being too concerned about what those annual premium increases were. Industry no longer wants to accept these annual increases. And I am saying that the world has changed in the contractor's area, where the pressures are very different there than they were prior to 1972.

In our area, too, our trust funds now are being threatened. The trustees estimate that by 1985, outlays may exceed income. Therefore, we have, I think, much more pressure right now than we had in the 1972 era.

Senator BAUCUS. Frankly, I do not think I fully understand what you are saying. I hear your words but I do not hear any reasons. I hear you restating your conclusion without any reasons for it.

What has changed?

Mr. THOMPSON. The pressures to——

Senator **Baucus**. What pressures?

Mr. **Thompson**. The pressures by the taxpayers' dollars, the pressures by the employers' dollars that are going into health.

Senator **Baucus**. And yet costs are going up significantly greater than the rate of inflation. Health care costs are going up much greater than the rate of inflation. It just seems to me that if we take a lid off, they are going to go up even greater.

Mr. **Thompson**. There has been no suggestion that we take any peer review or any review lid off. It just seems to me, having lived in this world, that it is an entirely different world now.

Senator **Baucus**. Which fiscal intermediaries today now pay hospital claims and would perform this function today?

Mr. **Thompson**. That——

Senator **Baucus**. Of the fiscal intermediaries that now pay hospital claims, which ones have you evaluated and found to have engaged in a broad and successful program of professional review?

Mr. **Thompson**. We have not made an indepth study on this, Senator.

Senator **Baucus**. Have you made a non-in-depth study?

Mr. **Thompson**. We have not made an indepth study of this.

Senator **Baucus**. Have you made a non-in-depth study?

Mr. **Thompson**. Yes. We have been in discussion with them and we have reviewed some of their review systems. And I would submit some of our findings for the record if you would like.

Senator **Baucus**. Can you give us some idea of the number of contractors that have a good track record here?

Mr. **Thompson**. I think that the majority of the contractors are able, are prepared to follow our direction and to put together an effective review mechanism.

Senator **Baucus**. Do you have any disagreement with the figures I mentioned in my opening statement, that is the dollar savings since 1972?

Mr. **Thompson**. No disagreement. The figures have been all over the lot, but they are certainly in the ballpark, Senator. I think that that is not a large enough savings.

Senator **Baucus**. Do you disagree with the statement too that annual changes in days of hospital care used per 1,000 medicare beneficiaries has decreased on an actuarial basis from 1981 to 1982? The figures I have are that from 1979 to 1980 there was a 5-percent increase in days of hospital care; 1980 to 1981, 2-percent increase, but in 1981 to 1982, 0.2-percent decline in the number of days of hospital care per 1,000 medicare patients.

Mr. **Thompson**. Senator, I definitely think progress has been made. My feeling, though, is that not enough progress has been made. If you can accept an estimate that there may be as high as 10 percent of overutilization in the health care world, then I would hate to settle for substantially less than that.

Senator **Baucus**. As you know, GAO does not believe that the department is ready to get into competitive bidding, even in the relatively simple area of claims payment, and they base their conclusion on the failures in Illinois and also the partial failures in New York, and also in your contracting demonstrations.

Given these problems, why do you think that you can handle a far more complex matter, professional review?

Mr. **Thompson**. Senator, I would certainly argue with GAO as to their findings. I think that we have taken a very complicated arrangement and I think we have done an outstanding job in contracting. I do not think anybody can go into a program as complicated as this and experiment and not have some places where you have failure.

Congress gave us the right to experiment in order to learn. Experimenting and learning means you make mistakes once in a while. We have learned from the mistakes, and I think that I would argue with the GAO that if they would look again with an open mind, that they might get an entirely new reading on our contracting ability.

Senator **Baucus**. Following up on a question by Senator Durenberger, what assurance is there that physicians would actually be the reviewers; that is, that there be peer review? As I understand the proposal, any contractor could conduct this review and it need not be physicians. It could be anybody.

So what assurance is there that there be actual peer review?

Mr. **Thompson**. I do not know of a single contractor that does not use physicians in the review process.

Senator **Baucus**. But what assurances are there, that there would be the same degree of peer review as in PSRO's?

Mr. **Thompson**. Under our plan, where we would turn the review over to the contractors, we would insist that they submit their plan and their procedure to us, and if there were no doctors included in the system, it would be unacceptable to us.

We do not disagree with the peer review concept. We do not disagree with the fact that a doctor needs to make the decision that there is inappropriate utilization.

We also feel that those doctors should be practicing physicians. They should be physicians who are respected in their community and whose decisions can stand the light of day. So that we would be very careful in that regard if our proposal prevailed.

Senator **Baucus**. I may have missed this, but do you have any estimates as to dollar savings under your recommendation?

Mr. **Thompson**. We have an estimate in the budget, an estimate that is our best——

Senator **Baucus**. What is that?

Mr. **Thompson**. The estimate is $330 million.

Senator **Baucus**. $330 million?

Mr. **Thompson**. Yes.

Senator **Baucus**. Compared with the present peer review system, is that right?

Mr. **Thompson**. Yes.

Senator **Baucus**. As annual savings?

Mr. **Thompson**. Annual savings.

Senator **Baucus**. Do you have data to support that?

Mr. **Thompson**. We have data to support that, which we can supply for the record if you would like.

Senator **Baucus**. Would you please, fully?

Senator **Durenberger**. And quickly.

Mr. **Thompson**. You must realize that the savings are calculated not only on our proposal, but also some expected savings from the coalitions and the work that is coming out of the private sector. We would be glad to submit something for the record.

[The following was subsequently submitted by George Thompson:]

CONTRACTOR AND VOLUNTARY EFFORT SAVINGS

As a result of savings achieved through the streamlining of Medicare Contractor operations, we will be able to shift additional funds into medical review. We plan to allocate those funds to contractors on the basis of those areas of the country in which we think they will have the most impact in reducing aberrant utilization patterns. By setting outcome-oriented benefit dollar savings targets for the contractors to meet, and by giving them flexibility in designing their review process to focus on local patterns of aberrances, we believe that significant progress can be made toward reducing Medicare payments for unnecessary utilization.

With respect to voluntary efforts by hospitals to contain health care costs, we believe there is a recognition among industry, labor, management and consumers, that innovative ways must be found to restrain the massive rates of increase in health care costs. We are in close contact with the industry and these coalitions and believe that a very strong effort to meet this target will be made.

The regional variation in lengths of stay and patterns of utilization suggest that the combined efforts of HCFA and private groups can achieve budgeted savings in a number of ways. Some examples of actions that could produce these savings include such things as:

- reduce average length of stay by 1/3 of a day, or
- reduce overall hospital utilization by 3.3%, or
- reduce expenditures for ancillary services by 2%.

Senator BAUCUS. One final question. Could we not have those savings from the coalition anyway?

Mr. THOMPSON. Part of them, I would say yes.

Senator BAUCUS. How much? What portion?

Mr. THOMPSON. That is very difficult to——

Senator BAUCUS. What is your best guess?

Mr. THOMPSON. I am sorry. I just could not guess at this moment.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. Thank you very much, Mr. Thompson. We appreciate your being here.

Our next witness will be the Honorable Ron Paul, Congressman from Texas. Ron, thank you for participating here this morning and we welcome your willingness to come over. Your statement, if you have a full statement, will be included in the record in full and you can abbreviate it, or do as you please.

STATEMENT OF HON. RON PAUL, M.D., U.S. REPRESENTATIVE FROM TEXAS

Dr. PAUL. Thank you, Mr. Chairman. I think I will go through my statement. It is a short statement and will not take very long.

I do appreciate your having me here at the hearings because this is an issue that is of deep interest to me, not only as a Congressman, but as a physician as well.

I come before you today to discuss S. 2142 from a particular point of view. My view quite simply is that the less Government involvement we have in all facets of medical care, the better.

Proponents of S. 2142 have claimed that it is designed to help deregulate PSRO's by allowing the Government to contract the PSRO function out to the private sector. However, I believe this is essentially a distinction without a real difference. After all, what real difference does it make whether the Federal Government contracts out the enforcement of harmful regulation or undertakes the enforcement on its own? The taxpayers are still stuck with the bill. Physicians must still comply with Government edicts or face sanctions. And all enforcement decisions still reside with the Secretary of Health and Human Services.

Moreover, this bill would require the Secretary of Health and Human Services to enter into performance-based contracts with PSRO's already in existence and to mandate the establishment of new PSRO's where none now exist. In this view, S. 2142 would institute PSRO through the country on a mandatory basis. Clearly, this bill is designed to put into place an even more pervasive system of federally financed review programs than already exist. In no way is it a deregulatory effort.

S. 2142 will continue the practice of utilizing nonphysicians in the reviewing process. This in my estimation is a violation of section 1801 of the original Medicare Act, which promises not to interfere in medical decisions.

It is further claimed that PSRO's are cost effective and that an expansion of PSRO's would thus increase savings. But the facts dispute this claim. Even the Congressional Budget Office has observed that the "PSRO review has reduced medical care outlays but the Federal Government saves little more than the cost of the review itself. When the increased cost to private patients resulting from the PSRO system are taken into account, PSRO review saves society as a whole substantially less than it costs."

Though Government medical planners and regulators often tend to forget private hospitals, clinics, and medical practices are businesses, when the Federal Government increases costs by increasing the regulatory burden, these businesses, like all others, must pass the increased costs along to the customers. Thus, the American taxpayer who pays for his own medical care actually pays twice. First he pays for PSRO through taxes. Then he pays for PSRO through the higher health insurance premiums and out of pocket costs that he bears for his own medical care. These kinds of savings are no savings at all.

But even more disturbing than the cost in dollars of an increased PSRO presence is the cost in terms of human freedom. PSRO's, in frank terms, represent our Nation's distressing creep toward State control of medicine. S. 2142 continues the $5,000 sanction against providers "in case such acts or conduct involve the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary." Such sanctions are serious interferences with personal freedom.

When the Federal Government first began its move toward guaranteeing free, unlimited medical care to all Americans, the price of medical care started to rise. But rather than restraining its spending, the Government chose instead to increase the level of subsidization. Soon these levels reached astronomical heights. Still no corrective action was taken.

But with a seemingly bottomless pool of taxpayers' dollars available for federally subsidized medical care, small wonder that the pool needed constantly to be refilled. Yet, now it is not green dollars, but red ink that fills the Government's pool. And still we search for solutions from the very sector that creates the problem—the Federal medical planners and regulators.

The solution to the problem of Government intervention in medical care is not more intervention in medical care. The solution is rather the exact opposite. The Government should withdraw from medical care completely.

The PSRO system is Government medicine, and S. 2142, by enlarging this system so significantly, represents another giant step toward national health care. We know what a disaster this has been in every place it has been tried, and we know that the PSRO system has not worked so far in this country. Those who have been able to withdraw from the system after experiencing it firsthand have often chosen to do so. This bill would take away that choice by mandating participation in the Federal PSRO system.

It is ironic, I believe, to note that when physicians' groups have attempted to provide self-regulation, the Government has tried its best to squelch its efforts. The Federal Trade Commission has declared these self-policing professional groups to be in violation of antitrust laws and has outlawed their very existence. How ironic that with one agency the Government tries to create a mechanism for filling a need and with another agency it stamps out private organizations that are actually meeting the same need.

Instead of spending our time and the taxpayers' money trying to devise new ways to regulate medical care, I recommend at least try a new approach: the Government should get out of medical care and let the free market provide the planning.

Federal intervention can in no way improve medical care, but it can impose higher costs and make it much harder for physicians to do their real job—that is, to care for patients. That is what has happened in the past with PSRO's and the problem will only get worse if the PSRO presence is increased.

It is the well-being of the patient that is the first concern of the providers, but it is the enforcement of regulations that is the first concern of quasi-governmental agencies. The subordination of the patients' interests to the interests of the bureaucrats is characteristic of all Government interference in medical care, and the more extensive that interference, the more the interest of the patient suffers.

I believe Americans deserve the very best medical care available. That is something only the free market and free men and women working freely in the market can provide. It is long past time to admit the abysmal failure of Government planning and regulation of medical care.

I would like to add just one personal note. It has not been too many years since I was in the practice of medicine and this subject came up frequently. The PSRO of course was offered in Texas and it was rejected. We do not have one in Texas. But we do have regulations and concerns and involvement with medicare. And because of the fear of Government coming in, it was a habit of many physicians, instead of continuing along with a patient who may be able to make partial payments, to convert that patient to a total charity patient, or to reject him, mainly because we were sick and tired of filling out the forms.

So, in many ways in the small town where I live, it really backfired. The patients who needed the help most were then forced to get in an automobile and ride 60 or 70 miles either to Galveston or Houston. So this was not helpful.

The other thing that is in the bill that I think is dangerous as far as good medical care goes, is that the PSRO representatives would be authorized to examine the private files of medical care practitioners. Of course they have to if they want to review the care. But this does one thing. As soon as that happens, physicians automatically quit making good records, mainly because there are a lot of things in a private medical record. As soon as I knew the Government was becoming more involved and medicare was being involved, it is the natural tendency of most physicians to put less information on the chart, especially information that could be of a personal nature but could be helpful to us in the care of the patient.

So a lot of these well-meaning regulations usually backfire and the patient suffers. I thank you very much.

Senator **Durenberger**. Thank you very much for your testimony. Your statement begins with "The less Government involvement we have in all facets of medical care, the better," and it ends with the statement that "Government should get out of medical care."

What are your views on medicare?

Dr. **Paul.** I think it is an improper function of the Federal Government.

Senator **Durenberger.** And your views on medicaid?

Dr. **Paul.** It is an improper function of the Federal Government under the Constitution of the United States.

Senator **Durenberger.** Thank you very much.

Senator Baucus?

Senator **Baucus.** Does that mean we should repeal medicare and medicaid?

Dr. **Paul.** If we followed the Constitution, they would be repealed because they have done more harm to the medical care of the people and to the poor than they have helped because they have driven the price up; they have put a lot of people out of the market; they have harmed medical care; and for all those dollars you take out of the economy to put into so-called medical care are the very dollars that are necessary to be allowed to remain in the market or at the local level to be used in——

Senator **Baucus.** I understand where you are coming from, I think.

Dr. **Paul.** Pardon me?

Senator **Baucus.** In an earlier reincarnation, I was an attorney and I can tell you from my experience in the practice of law that there are some very good attorneys. Most attorneys are very good and very competent, but there are also a good number of attorneys in my experience who are incompetent, and I suspect the same is true in medicine. Most physicians are very good and very competent, but there are probably a few who are incompetent.

What does the average person do when he is seeking quality health care, for example, and wants obviously to be taken care of and does not want to pay exorbitant medical bills, particularly in an area where it is hard to know when you are getting good health care or not? How do we weed out the rotten physicians? I grant you there are not very many but there are probably a few. So what do we do?

Dr. **Paul.** Well, you get the Government out of the way because the Government protects them. I mentioned the Federal Trade Commission. We have our own review committees in our county medical societies which now are illegal. If you as a patient feel like you are overcharged, before, you would come to the medical society, it would be reviewed and the doctor would be reprimanded, and he would change his ways. Today that is illegal.

There have been many examples of bad physicians who have been on the staffs of hospitals that we cannot get off, mainly because of State regulations for licensure, because of Federal laws that state that if there were Federal moneys put into the hospital, therefore you will have to follow Federal laws, which means that we cannot get rid of the bad doctors. So get rid of the Government's controls and we will get rid of the bad doctors.

Senator **Baucus.** You are telling us what we should not do, what we should not do. I am asking what we should do.

Dr. **Paul.** What we should do is get rid of Government regulations that have set up and helped keep the bad doctors practicing medicine. What do we do with bad attorneys?

Senator BAUCUS. So you are saying the Government should do nothing, zero.

Dr. PAUL. The Government should protect our freedom, and then our free people will provide our care. If we base our assumption that Government can provide a good service or a service effectively, you have to accept the general notion of why does the Government not provide all goods and services, which is of course accepting the idea of socialism.

Senator BAUCUS. I am not arguing with you here. I am just trying to figure out what your position is.

Dr. PAUL. So if you accept this idea, fine, but the evidence is pretty clear that all that happens is the services deteriorate. How do we provide bread for the public? I mean, do you inspect every loaf of bread?

Senator DURENBERGER. We support the price of wheat. I can answer that one. For a lot of Texas farmers.

Senator Bradley.

Senator BRADLEY. No questions, Mr. Chairman.

Senator DURENBERGER. Thank you very much for your testimony. We appreciate it.

Dr. PAUL. I am sure I have converted you both.

[The prepared statement of Hon. Ron Paul, M.D., Congressman from Texas, follows:]

TESTIMONY
PRESENTED TO THE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
UNITED STATES SENATE
on
S.2142
"PEER REVIEW IMPROVEMENT ACT OF 1982"
by
HON. RON PAUL, M.D.
MEMBER OF CONGRESS
April 1, 1982

As a member of Congress and a practicing physician, I come before you today to discuss S.2142 from a particular point of view. My view, quite simply, is that the less government involvement we have in all facets of medical care, the better.

Proponents of S.2142 have claimed that it is designed to help deregulate PSROs, by allowing the government to contract the PSRO function out to the private sector. However, I believe this is essentially a distinction without a real difference. After all, what real difference does it make whether the federal government contracts out the enforcement of harmful regulations, or undertakes the enforcement on its own? The taxpayers are still stuck with the bill, physicians must still comply with government edicts or face sanctions, and all enforcement decisions still reside with the Secretary of Health and Human Services.

Moreover, this bill would require the Secretary of Health and Human Services to enter into "performance based contracts" with PSROs already in existence, and to mandate the establishment of new PSROs where none now exist. In this way, S.2142 would institute PSROs (renamed "quality control and peer review organizations") throughout the country, on a mandatory basis. Clearly, this bill is designed to put into place an even more pervasive system of federally financed review programs than already exists. In no way is it a deregulatory effort.

S.2142 will continue the practice of utilizing non-physicians in the reviewing process. This is a violation of section 1801 of the original Medicare Act which promises not to interfere in medical decisions.

It is further claimed that PSROs are cost-effective, and that an expansion of PSROs would thus increase savings. But the facts dispute this claim. Even the Congressional Budget Office has observed that "PSRO review has reduced Medicare outlays, but the federal government saves little more than the cost of the review itself.... When the increased costs to private patients [resulting from the PSRO system] are taken into account, PSRO review saves society as a whole substantially less than it costs."

Though government medical planners and regulators often tend to forget, private hospitals, clinics, and medical practices are businesses. When the federal government increases costs by increasing the regulatory burden, these businesses (like all others) must pass the increased costs along to consumers. Thus, the American taxpayer who pays for his own medical care actually pays twice: First, he pays for PSRO through taxes, and then he pays for PSRO through the higher health insurance premiums and out-of-pocket costs that he bears for his own medical care.

These kinds of "savings" are no savings at all.

But even more disturbing than the cost in dollars of an increased PSRO presence is the cost in terms of human freedom. PSROs, in frank terms, represent our nation's distressing creep toward state control of medicine. S.2142 continues the $5,000 sanction against providers "...in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary...." Such sanctions are serious interferences with personal freedom.

When the federal government first began its move toward "guaranteeing" free, unlimited medical care to all Americans, the price of medical care started to rise. But rather than restraining its spending, the government chose instead to increase the level of subsidization. Soon these levels reached astronomical heights. Still no corrective action was taken. But with a seemingly bottomless pool of taxpayers' dollars available for federally-subsidized medical care, small wonder that the pool needed constantly to be refilled!

Yet now it is not green dollars, but red ink, that fills the government's pool. And still we search for solutions from the very sector that created the problem--the federal medical planners and regulators.

The solution to the problem of government intervention in medical care is not more intervention in medical care. The solution is, rather, the exact opposite: The government should withdraw from medical care completely.

The PSRO system is government medicine--and S.2142, by enlarging this system so significantly, represents another giant step toward "national health care," or "socialized medicine." We know what a disaster this has been in every place it's been tried, and we know that the PSRO system has not worked so far in this country. Those who've been able to withdraw from the system, after experiencing it firsthand, have often chosen to do so. But this bill would take away that choice, by mandating participation in the federal PSRO system.

(It is ironic, I believe, to note that when physicians' groups have attempted to provide self-regulation, the government has tried its best to squelch the efforts. The Federal Trade Commission has declared these "self-policing" professional groups to be in violation of the antitrust laws, and has outlawed their very existence. How ironic--with one agency the government tries to create a mechanism for fulfilling a need, and with another agency it stamps out private organizations that are actually meeting that same need.)

Instead of spending our time and the taxpayers' money trying to devise new ways to regulate medical care, I recommend that we at least try a new approach: The government should get out of medical care, and let the free market provide the planning.

Federal intervention can in no way improve medical care, but it can impose higher costs and make it much harder for physicians to do their real job--that is, to care for patients. This is what has happened in the past with PSROs, and the problem will only get worse if the PSRO presence in increased. It is the well-being of the patient that is the first concern of the providers, but it is the enforcement of regulations that is the first concern of quasi-governmental agencies. The subordination of the patient's interests to the interests of the bureaucrats is characteristic of all government interference in medical care, and the more extensive that interference, the more the interests of the patient suffer.

I believe Americans deserve the very best medical care available. That is something only the free market, and free men and women working freely in the market, can provide. It is long past time to admit the abysmal failure of government planning and regulation of medical care.

Senator DURENBERGER. Thank you.

Our next panel consists of Dr. John Sunderbruch, president, accompanied by Mr. Boyd Thompson, executive vice president of the American Association of Foundations for Medical Care in Bethesda; Dr. Harry Weeks, chairman of the legislative committee, accompanied by Ms. Lyle Hernandez, executive director, American Association of Professional Standards Review Organizations, Bethesda, Md. Welcome.

Go ahead, John.

STATEMENT OF DR. JOHN SUNDERBRUCH, PRESIDENT, AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE, BETHESDA, MD., ACCOMPANIED BY BOYD THOMPSON, EXECUTIVE VICE PRESIDENT

Dr. SUNDERBRUCH. Mr. Chairman, my name is John Sunderbruch. I am president of the American Association of Foundations for Medical Care and a practicing physician in Davenport, Iowa. I am accompanied by Mr. Boyd Thompson, executive vice president of our association.

I appreciate this opportunity to present the views of our association on S. 2142, a bill to provide for a new system of utilization and quality control peer review to be made available to public and private third party purchasers of medical care.

The American Association of Foundations for Medical Care originated as a regional group of foundations for medical care based primarily in the far west. FMC's were the first physician organizations to establish sophisticated, effective programs of peer review of the utilization of physicians' services and became prototypes of both IPA/HMO's and PSRO's. The major difference was that the efforts were totally private. IPA's and related HMO's now make up a major part of our association. Some years ago we helped organize the American Association of Professional Standards Review Organizations.

The commitment for our organization to improve competition in health care is a matter of public record for many years now. Our commitment continues, as evidenced by our sponsorship of the Age of Competition Conference on January 8 of this year. We would like again to express our deep personal thanks, Mr. Chairman, for your highly praised participation in that conference.

Many FMC programs take the form of a cooperative venture between the foundation, the consumer or his management trust fund and a third party payer, such as Blue Cross/Blue Shield, a commercial insurance company, or government.

The foundation defines a comprehensive health benefit program suited to the needs of a particular subscriber group. The foundation then develops an agreement with its member physicians and other providers which gives the patient certainty of cost and coverage. By certainty of cost, I mean a maximum payment schedule and agreement by physician and provider not to charge the patient any additional amounts.

The physicians agree further to accept a formal system of peer review by colleagues in active medical practice, and to the greatest extent possible, to participate in this review process. FMC peer review comprises much more than evaluating physicians' charges. Indeed, the quality of care and the appropriateness of the services involved are the prime focal points of FMC monitoring.

When it has agreed to administer a given health benefit program, the foundation will contract with insurers and employers to assure the patient of quality care and reasonable access to services, at a predictable cost. In effect, it will commit the community medical system to delivery of health services in an organized mode—not under one group, as in a group practice health maintenance organization—but within the framework of a private practice, under a management system sponsored by the foundation.

Peer review of the professional services rendered under FMC auspices is the heart of the foundation's service program and in many areas, that is the sole or principal function of the FMC. There are a variety of local pattern based on local needs and resources of each community.

In peer review, the final distribution of benefit payments is authorized only after approval, not by a third party payer, lay and remote, but by one's own local peers in medical practice. This approach has almost always proved effective. A provider of health services does not dismiss lightly the genteel disagreement of his colleagues.

While due attention is given to the fees charged for professional services, the major emphasis of the review program is on utilization of health services. The number of visits, the number of elective surgical procedures, the appropriateness of the care rendered and the hospital admissions, the length of stay in institutions—these and other factors have become components of a sophisticated peer review activity.

I can illustrate this point further, Mr. Chairman, by describing some of the activities in my own foundation. The Iowa Foundation for Medical Care serves as a good example of how a peer review organization can serve the interests of both the public and the private sectors. The IFMC was created in 1971 by the physicians of Iowa to serve as a statewide private nonprofit peer review organization. Since its creation, the foundation has grown to a point where it provides review for 20 private clients. Currently the IFMC scope of review includes 131 hospitals, 460 long-term care facilities, 26 skilled nursing facilities and 4 mental health facilities. Annually the foundation reviews approximately 425,000 patients in all of these facilities.

The foundation has been able to document its impact on health care utilization during its years of existence. The foundation's activities have produced a steady decline in medicare and medicaid utilization since it began Federal review in 1977. We in fact have considered ourselves contracting with the Federal Government to do the PSRO.

Given this understanding of how FMC's work, you can appreciate, Mr. Chairman, why AAFMC is interested in and supportive of your bill. It is quite likely that some of our members will be very interested in responding to the incentives in your bill for effective private review as well as review for public programs.

We agree with your basic premise in fashioning this legislation, that effective and efficient peer-based utilization review will be a necessary part of any new effort to inject competition into the health care field. The mechanism called for in your bill will do much to further this objective. We are in fact delighted that you support both increased competition and effective peer review, and we pledge to continue to work with you to accomplish our mutual objectives.

The main message we want to leave with the committee is that we believe S. 2142 is on target and we wholeheartedly support the thrust of this legislation. We will be glad to work with the committee and its skillful staff to move the legislation to enactment. I will answer any questions if necessary.

[The prepared statement of John Sunderbruch, M.D., follows:]

TESTIMONY OF THE
AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE

PRESENTED BY

JOHN SUNDERBRUCH, M.D.

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The commitment of our organization to improved competition in health care is a matter of public record for many years now. Our commitment continues, as evidenced by our sponsorship of the Age of Competition Conference on January 8 of this year. We would like, again, to express our deep personal thanks, Mr. Chairman, for your highly praised participation in that Conference.

A brief description of how these original FMCs worked will be helpful, I believe, in understanding these complex and different organizations.

Many FMC programs take the form of a cooperative venture between the Foundation, the consumer or his management trust fund and a third party payer (Blue Cross/Blue Shield, a commercial insurance company or government). The

Foundation defines a comprehensive health benefit program suited to the needs of a particular subscriber group. The Foundation then develops an agreement with its member physicians and other providers which gives the patient certainty of cost and coverage. By certainty of cost, I mean a maximum payment schedule and agreement by physician and provider not to charge the patient any additional amounts. The physicians agree further to accept a formal system of "peer review" by colleagues in active medical practice and, to the greatest extent possible, to participate in this review process. FMC peer review comprises much more than evaluating physicians' charges. Indeed, the quality of care and the appropriateness of the services involved are the prime focal points of FMC monitoring.

When it has agreed to administer a given health benefit program, the Foundation will contract with insurers and employers to assure the patient of quality care and reasonable access to services -- at predictable cost. In effect, it will commit the community medical system to delivery of health services in an organized mode -- note under one roof, as in a "group practice health maintenance organization" -- but within the framework of private practice, under a management system sponsored by the Foundation.

"Peer review" of the professional services rendered under FMC auspices is the heart of the Foundation's service program and, in many areas, that is the sole or principal function of the FMC. There are a variety of local patterns based on local needs and resources of each community. The earliest FMC, the San Joaquin Foundation, set the pattern more than thirty years ago when the local physicians "to accomplish the objectives of optimal quality, reasonable access and predictable cost" agreed among themselves to all claim forms before payment.

In peer review, the final distribution of benefit payments is authorized only after approval, not by a third party payer (lay and remote), but by one's own local peers in medical practice. This approach has almost always proved effective. A provider of health services does not dismiss lightly the genteel disagreement of his colleagues. While due attention is given to the fees charged for professional services, the major emphasis of the review program is on utilization of health services. The number of visits, the number of elective surgical procedures, the appropriateness of the care rendered and the hospital admissions, the length of stay in institutions -- these and other factors have become components of a sophisticated peer review activity.

I can illustrate this point further, Mr. Chairman, by describing some of the activities in my own Foundation. The Iowa Foundation for Medical Care serves as a good example of how a peer review organization can serve the interest of both the public and private sectors. The IFMC was created in 1971 by the physicians of Iowa to serve as a statewide, private non-profit peer review organization. Since its creation, the Foundation has grown to a point where it provides approximately 20 private clients. Currently, the IFMC scope of review includes 131 hospitals, 460 long-term care facilities, 26 skilled nursing facilities and four mental health facilities. Annually, the Foundation reviews approximately 425,000 patients in all of these facilities.

The Foundation has been able to document its impact on health care utilization during its years of existence. The Foundation's activities have produced a steady decline in Medicare and Medicaid utilization since it began federal review in 1977. In addition, the Foundation has also shown impact on the private side. One private client benefited from an

18.7% reduction in the number of hospital days per thousand people and a 10.6% reduction in admissions per thousand during the first two years of review. Blue Cross of Iowa mandated utilization review for its policies through the IFMC effective January 1, 1981, for 96 hospitals participating in their program. Other private insurance carriers are joining the IFMC's program to help assure appropriate utilization.

Given this understanding of how FMCs work, you can appreciate, Mr. Chairman, why AAFMC is interested in and supportive of your bill. It is quite likely that some of our members will be very interested in responding to the incentives in your bill for effective private peer review, as well as review for public programs.

We agree with your basic premise in fashioning this legislation -- that effective and efficient peer-based utilization review will be a necessary part of any new effort to inject competition into the health care field. The mechanism called for in your bill will do much to further this objective. We are, in fact, delighted that you support both increased competition and effective peer review, and we pledge to continue to work with you to accomplish our mutual objectives.

The main message we want to leave with the committee is that we believe S.2142 is on target, and we wholeheartedly support the thrust of this legislation. We will be glad to work with the committee and its skillful staff to move the legislation to enactment.

Mr. Chairman, I will be glad to answer any questions you or other members of the subcommittee may have.

Senator DURENBERGER. Thank you very much. Dr. Weeks.

STATEMENT OF DR. HARRY WEEKS, CHAIRMAN OF THE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, BETHESDA, MD., ACCOMPANIED BY MS. LYLA HERNANDEZ, EXECUTIVE DIRECTOR

Dr. WEEKS. Mr. Chairman, my name is Harry Weeks. I am a practicing physician from Wheeling, W. Va., past president of the AAPSRO and with me today is Lyla Hernandez, our executive director. I appreciate very much this opportunity to testify.

As you are aware, Mr. Chairman, the PSRO program has been evaluated time and time again by many people. In my submitted testimony I presented detailed statistics on the effectiveness of the PSRO's. The bottom line is that they save more Federal dollars than they cost.

Perhaps the best indication today that we are effective is reflected by the fact that those who have had an opportunity to contract with PSRO's for review are now doing so. Twenty-six States have entered into medicaid review contracts with PSRO's, and while some are still being continued under a Federal grant process, it is anticipated that most of the States will pick up the option to contract with PSRO's.

Our members report that 67 PSRO's have signed contracts for private review and an additional 18 are in the process of negotiating contracts.

Though we are pleased to be able to report these accomplishments, we agree that changes can be made which would improve the program.

The most far-reaching bill before you is your bill, S. 2142, and we see several important advantages in that bill. Perhaps the foremost of these from the perspective of our members is the clear intent to avoid the day-by-day involvement of HHS employees. We also support the provisions which encourage private review.

In addition, we strongly support the changes which would be made regarding sanctions. Our experience with the bureaucracy has been poor. Once a PSRO has reached the point of recommending a sanction, you may be sure that the individual or organization involved is a very poor performer indeed. The Department has acted but frequently takes years to act on these recommendations and meanwhile, the one being recommended for sanction continues to harm patients.

While we favor the major purposes of S. 2142 and S. 1250, extended discussions with our membership reveal their reluctance to support S. 2142 without certain changes which we believe would improve the prospects that we will reach our common objectives.

First, we strongly believe that preference for review organizations should be given to nonprofit physician organizations. We would further urge the committee that when defining the requirement that a review organization be composed of a substantial number of practicing physicians, that the word "substantial" be defined to mean a large proportion of the practicing physicians in an area, perhaps on the order of 30 to 40 percent.

Second, while we understand that the intent of the provisions of Senator Baucus' bill and in the chairman's bill to require that review organizations be based primarily at the State level is to produce administrative cost savings and to facilitate private review, we believe that a move to eliminate existing PSRO's with proven track records would be counterproductive. We also believe that the minimum number of hospital admissions required for area designation should reflect all admissions, not just medicare admissions.

And finally, we believe that the health insuring organizations themselves not be permitted to be peer review organizations. Our rationale for this is twofold. First, insurance companies compete among themselves. If one of them were to be a review organization, the requirement in the bill that it offer its services to other insurers would simply not be taken up by their competitors, thus blocking the possibility of private review in that area.

Second, it is quite clear that despite their own evaluations that PSRO's are effective and are producing savings, the administration is determined to eliminate PSRO's or any type of peer review organization. They have shown that they wish to use fiscal intermediaries to conduct review, even though there is absolutely no evidence to support the contention that this approach would be more effective than PSRO. In fact, the evidence is to the contrary.

If S. 2142 allows insurance companies to compete for review contracts, the possibility exists that the administration would ignore the intent of the legislation and choose insurers over peer review organizations.

Moreover, we share Senator Baucus' concern that the administration would simply use S. 2142, if passed as now drafted, to eliminate peer review.

We have, quite frankly, no specific changes to suggest be made in the bill beyond those already described. We do believe, however, that if the committee approves the legislation that it should obtain specific agreements from those in the Department that they will administer the program in the manner intended.

Mr. Chairman, we thank you for the subcommittee's time and attention. We would be glad to answer any questions.

[The information presented by the AAPSRO follows:]

PSRO IMPACT
ON
MEDICAL CARE SERVICES: 1981

A Report of the 1981 AAPSRO Impact Committee

B. Marc Allen
Chairman

INTRODUCTION

The Professional Standards Review Organization (PSRO) program was created by P.L. 92-603 in 1972 for the purpose of assuring that health care services delivered to Medicare and Medicaid patients are necessary, appropriate and of acceptable quality. PSROs are independent, local, organized, physician member organizations which have accepted the responsibility for monitoring the delivery of health care services to Medicare and Medicaid patients and taking action to correct identified problems. The philosophy of why approximately 150,000 physicians are involved in PSRO review can, perhaps, best be reflected by a statement made by one of these physicians.

> "We recognize that there is a finite limit to resources; therefore, there is a finite limit to health care funds. If any funds expended are for unnecessary, inappropriate, or unreasonably expensive services, the remaining reduced funds will purchase less health goods and services, thus potentially reducing the overall quality of health care."

There are presently 147 PSROs conducting review of the medical necessity and quality of services. Many PSRO results are statistically measurable in terms of reduced hospital use and reduction of waste. Other results are more subjective or problem related and are best reported by describing local experiences.

All PSROs do not address the same specific topics in their daily activities of reducing unnecessary utilization and improving the quality of services. Congress, in its wisdom, established PSROs as local physician organizations so that each could identify significant problems in their areas and devise and carry out strategies to correct them. As a result, not all PSROs direct their resources at reducing overall length of stay or days of care per thousand because not all have current problems in those areas. Many PSROs spent their early years concentrating their efforts on unnecessary hospital care but once these areas were brought under control, they used their data systems to identify other problems in their areas.

The purpose of this report, then, is to provide an overview of the achievements of PSROs for those areas which can be more readily quantifiable (utilization) as well as for those areas which cannot readily be measured by numbers but which produce improvements in quality.

METHODOLOGY

In June, 1981 a questionnaire was mailed to each PSRO asking for delineation of the areas where each felt it had achieved impact. One hundred four responses were received. These 104 PSROs conducted review of 7,289,874 discharges or 60% of the total federal discharges reviewed by PSROs.

The responses have been divided into two major categories: 1) impact on reducing unnecessary utilization; and 2) impact on improving quality.

REDUCING UNNECESSARY UTILIZATION

Many PSROs across the country reported that they had identified utilization problems within their areas and had acted to correct those problems. For purposes of this report it is impossible to relate the hundreds of specific examples reported. We have, however, chosen a few examples to provide an overview of the kinds of impact PSROs have achieved.

For many of these areas we have attempted to calculate the total reductions in days of hospital care as well as the amount saved through these reductions. The more basic and useful figure is days of hospital care saved per thousand beneficiaries, and that figure has been used when available. To the extent that the same PSROs reported impact in more than one area (e.g., reduction in average length of stay and in days of care/1,000 Medicare beneficiaries) it is, of course, not appropriate to add each separate category to arrive at total days saved.

Reductions in overall length of stay (ALOS) for Medicare and Medicaid. Twenty-two PSROs reported that they had identified problems in the ALOS for Medicare and had taken corrective action. These PSROs reported drops in the Medicare ALOS ranging from .1 days to 1.7 days (see Table 1, pages 10-13).

To calculate the actual number of days saved through this reduction, the number of Medicare discharges in the year showing reduction is multiplied by the decrease in ALOS between the baseline year and the year of reduction for each PSRO.

These 22 PSROs, then, reported a decrease of 504,359 days achieved through reductions in ALOS for Medicare.

The American Hospital Association reports that the average adjusted cost per patient day for a hospital to provide services to a patient is $245.12. In order to calculate the amount of dollars saved through this reduction in days one cannot assume that the full 100% of the $245.12 per day is saved. The Health Care Financing Administration has used 40% of the cost of a day to calculate the amount saved by PSROs. For purposes of this report, we have used an even lower figure of 33% of the cost of a day as the amount saved.

Given the above, then, the 504,359 days reduction reported by these twenty-two PSROs yields a savings of $40,797,600.

Twelve PSROs reported on reductions in ALOS for Medicaid (see Table 2, pages 14 & 15). The extent of these reductions ranged from .2 days to 1.3 days. The total reduction in days achieved by these twelve PSROs through reductions in Medicaid ALOS was 140,654 days.

Again, using 33% of the cost of a hospital day as the amount saved, the 140,654 day reduction amounts to a savings of $11,377,502.

Looking at the single area of reductions in ALOS for Medicare and Medicaid together, then, we see that the PSROs reporting on these areas showed a reduction of 645,013 days for a dollar savings of $52,175,102.

Reductions in days of care/1,000 (DOC/1,000) for Medicare and Medicaid. Eleven PSROs reported they had identified a problem expressed as an excess of days of care/1,000 for Medicare patients and had intervened to reduce the extent of that problem (see Table 3, pages 16 & 17). The size of the decrease in Medicare DOC/1,000 ranged from an 11 day reduction to a reduction of 537 DOC/1,000. The total reduction of days attributable to the reports of these PSROs is 81,430 days.

Using 33% of the total cost of a hospital day as the amount saved, this 81,430 reduction in days represents a savings of $6,586,873.

Five PSROs reported that they had achieved reductions in Medicaid DOC/1,000 ranging from a decrease of 44 DOC/1,000 to a decrease of 613 DOC/1,000 (see Table 4, page 18). The total reduction in days reported by these PSROs amounted to 32,515 days for a savings of $2,630,138.

These PSROs, then, reported a reduction in days of care per 1,000 for Medicare and Medicaid amounting to a decrease of 113,945 days and a dollar savings of $9,217,011.

Reductions in procedure-specific length of stay. Thirty-eight PSROs, shown in Table 5 below, reported that they had identified problems of excessive length of stay for various procedures and had taken actions to correct those problems. These PSROs reported achieving reductions in procedure-specific lengths of stay amounting to a total of 39,146 days or $3,166,520 saved.

Table 5: Reductions in Average Length of Stay (ALOS) by Procedure by PSRO and Region of the Country

Region and PSRO	Procedure	ALOS		Days Saved
		1979	1980	
NORTHEAST				
Connecticut Area II PSRO	Fracture of bone with major surgery	19.0	18.2	720
Rhode Island PSRO	Cholecystectomy	15.1	13.2	1,081
	Total hip replacement	21.9	21.1	692
	T.U.R.P.	12.6	12.2	254
Five County Organization for Medical Care and PSR (New York)	Arteriography and Phlebography	11.4	7.8	468
	Appendectomy	9.3	7.6	150
	Low forceps with/ without Episiotomy	3.7	3.5	36
	Arthroplasty of hip	24.4	21.8	288
	T.U.R.P.	13.8	12.8	330
	Repair of Inguinal Hernia	7.4	6.6	232
	Repair of Abdominal Hernia	11.7	9.9	119
New York County Health Services Review (NY).	Abdominal Hysterectomy	13.0	12.7	164
	Vaginal Hysterectomy	11.0	10.5	105
	Lumbar Disc Excision	27.0	23.3	263
	Menisectomy	12.5	9.3	134
	T. & A.	2.0	1.9	59
	Disease of Gallbladder and Bile Duct with operation	10.6	10.5	46
	Disease of Prostate with T.U.R.P.	8.7	8.6	51
	Cholecystectomy	14.8	13.3	989
	Arthroplasty of hip	25.3	23.4	1,277
	T.U.R.P.	12.3	11.4	1,251

Region and PSRO	Procedure	ALOS		Days Saved
		1979	1980	
	Repair of Inguinal Hernia	6.8	6.3	894
	Repair of Abdominal Hernia age 64 with minor repair	6.9	6.5	676
	Suprapubic Prostatectomy	16.4	15.8	161
Kings County Health Care Review Organization (NY)	Pacemaker insertion repairs	16.3	15.6	910
	Cholecystectomy	18.1	17.3	800
	T.U.R.P.	17.4	15.7	2,890
Nassau PRO (NY)	Elective surgery	7.0	6.4	6,000
PSRO of Rockland (NY)	T.U.R.P.	13.7	12.1	256
Bronx PSRO (NY)	Benign Prostate Hypertraphy with T.U.R.P.	16.6	14.9	850
PSRO of Union County (NJ)	Maintenance Chemotherapy	2.2	1.9	46
	Insertion of permanent pacemaker	16.2	14.8	195
	Normal deliveries (Medicaid)	3.9	3.8	35
	Total Abdominal Hysterectomy	11.2	9.2	80
	Total Cholecystectomy (Medicare)	16.3	15.4	316
	Total Cholecystectomy (Medicaid)	11.9	10.0	114
	Suprapubic Prostatectomy (Medicare)	16.6	16.3	189
Passaic Valley PSRO (NJ)	Cholecystectomy	16.0	14.9	417
Southwestern Pennsylvania PSRO	Abdominal/vaginal Hysterectomy	8.4	7.6	116
	Hernia repair in hospital D (Medicare)	8.2	6.7	42
	Hernia repair in hospital E (Medicare)	10.6	10.4	10
	Hernia repair in hospital K (Medicaid)	7.9	4.9	30
	Hernia repair in hospital N (Medicaid)	8.1	6.1	10
Highlands PSRO Corp. (PA)	T.U.R.P.	5.9	3.6	666
Southcentral Pennsylvania PSRO	Abdominal hernia age greater 65 with major surgical repair	6.9	6.4	730
	Disease of vascular system with reconstruction of artery or amputation of extremity	21.1	19.6	1,073
SOUTH				
West Virginia Medical Institute	Normal delivery	4.2	3.6	180

Region and PSRO	Procedure	ALOS		Days Saved
		1979	1980	
Northern Virginia FMC	Unilateral repair of Inguinal Hernia	7.3	6.9	86
	T.U.R.P.	12.5	11.0	353
	Cholecystectomy	14.5	13.1	350
	Open reduction of fracture of femur with internal fixation	24.0	23.6	77
Colonial Virginia FMC	Minor repair of hernia of abdominal cavity	9.2	7.0	20
	Disease of Gallbladder and Bile Duct with operation	11.4	10.8	19
	Disease of female genital organs with hysterectomy	11.8	9.4	36
North Central Medical Peer Review Foundation (NC)	T.U.R.P.	11.1	11.0	56
	Cholecystectomy	13.7	12.9	302
Piedmont Medical Foundation (NC)	Hyperplasia of Prostate with T.U.R.P.	9.6	9.0	246
	Cholecystectomy	11.3	10.5	266
Community Medical Services Association (FL)	Cholecystectomy	14.8	12.1	1,361
Puerto Rico FMC	Cholecystectomy	Qtr.4 11.0	Qtr.4 9.6	104
	T.U.R.P.	Qtr.4 9.9	Qtr.4 9.1	114
	Hernia repair	Qtr.4 6.7	Qtr.4 6.4	28
	Open Reduction of fracture with internal fixation	1980 Qtr.1 21.0	1981 Qtr.1 19.2	58
CENTRAL				
Region X PRO (OH)	T.U.R.P.	1979 Qtr.1 15.1	1980 Qtr.1 12.8	364
	Cystoscopy	Qtr.1 11.2	Qtr.1 10.3	180
Physicians Peer Review Association (OH)	T.U.R.P.	Qtr.4 14.1	Qtr.4 11.2	204
Area VIII Peer Review Organization (OH)	Prostatectomy	13.1	12.2	54
	Breast biopsy	11.4	9.0	149
	Urethral dilation	10.0	8.9	88
	Transurethral destruction of bladder lesion	10.9	10.2	63
	Hemorrhoidectomy	9.7	8.9	41
Western Michigan PSRO	Hip fracture	28.0	26.0	360
Upper Peninsula Quality Association (MI)	Normal delivery	Qtr.1 3.7	Qtr.2 3.4	60

Region and PSRO	Procedure	ALOS		Days Saved
		1979	1980	
Foundation for Medical Care Evaluation of Southeastern Wisconsin	Cholecystectomy	15.4	15.3	9
		Qtr.1	Qtr.1	
	Inguinal or femoral herniorrhaphy	8.4	7.7	31
East Central Illinois FHC	T.U.R.P.	11.5	11.3	15
Medical Utilization Review of Southern Illinois	Dilation & Currettage	3.7	3.4	116
Kansas FMC	T.U.R.P.	12.6	11.2	3,041
Southeast Louisiana Medical Quality Review Foundation		1980 Qtr.1	1981 Qtr.1	
	T.U.R.P.	12.9	12.0	113
		1979 Qtr.4	1980 Qtr.4	
	Hernia repair	12.1	9.7	48
		1980 Qtr.1	1981 Qtr.1	
	Dilation & Currettage	3.8	3.2	200
WEST				
Utah PSRO	Inguinal herniorrhaphy	3.4	3.1	150
Greater Oregon PSRO	Suprapubic prostatectomy	10.1	7.9	75
Multnomah FMC (OR)	Meniscectomy	5.6	5.1	152
Area XXII PSRO (CA)	Cholecystectomy	16.3	13.1	2,627
Mid-Peninsula PSRO (CA)	T.U.R.P.	14.3	12.1	132
San Diego/Imperial PSRO (CA)	T.U.R.P.	8.0	7.0	150
San Francisco PRO (CA)	T.U.R.P.	7.6	6.1	265
Superior California PSRO	T.U.R.P.	6.6	6.2	220
	Total hip replacement	16.7	13.6	372

Reductions in diagnosis-specific length of stay. Table 6 shows the thirty-two PSROs which reported they had uncovered and corrected problems in lengths of stay for several diagnoses. Based upon PSRO actions, reductions totalling a savings of 43,547 days or $3,522,517 were achieved in this area.

Table 6: Reductions in Average Length of Stay (ALOS) by Diagnosis by PSRO and Region of the Country

Region and PSRO	Diagnosis	ALOS		Days Saved
		1979	1980	
NORTHEAST				
Western Massachusetts PSRO		1980 Qtr.1	1981 Qtr.1	
	Diabetes	15.4	12.1	743
Charles River Health Care Foundation (MA)		1979	1980	
	A.M.I.	16.4	15.3	396
	C.V.A.	13.0	12.8	67
Rhode Island PSRO	Congestive heart failure	12.0	11.4	1,319
PSRO of Rockland (NY)	A.M.I.	16.5	15.3	240
New York County Health Services Review	A.M.I.	18.0	17.3	1,348
	Diabetes	9.9	9.7	118
	Pneumonia, age>30 without operation	9.0	8.9	21
PSRO of Queens County (NY)	Heart failure	12.7	12.3	1,862
	Acute ischemic heart disease	9.8	9.2	947
	Pneumonia	12.0	11.6	1,282
	Complicated diabetes	15.1	14.0	1,186
	Uncomplicated diabetes	11.2	10.3	604
	A.M.I.	14.7	13.9	2,377
Five County Organization for Medical Care and PSR (NY)	A.M.I.	14.4	13.3	413
	Ischemic heart disease	11.3	8.3	586
Bronx PSRO (NY)	A.M.I.	17.5	16.9	600
PSRO of Union County (NJ)	C.V.A. (Medicare)	12.0	8.8	243
	Unspecified pneumonia (Medicare)	13.3	13.2	46
	Unspecified A.M.I.	13.3	12.3	347
	A.M.I. of other interior wall	14.5	13.7	97
Essex PRO (NJ)	A.M.I.	17.0	16.2	606
	Pneumonia age<31	6.9	6.5	393
Highlands PSRO Corp. (PA)	Ischemic heart disease	9.5	8.4	18
	Diabetes	12.7	9.7	18
	A.M.I.	20.6	18.1	176
Eastern Pennsylvania Health Care Foundation		Qtr.2	Qtr.2	
	A.M.I.	16.9	16.3	136
Southcentral Pennsylvania PSRO	Ischemic heart disease	9.6	9.0	1,316
	A.M.I.	16.3	15.7	1,316
Southwestern Pennsylvania PSRO	A.M.I.	17.0	16.7	249
	Congestive heart failure	11.3	11.2	220
SOUTH				
Montgomery County Medical Care Foundation (MD)	C.V.A.	20.1	17.5	101

Region and PSRO	Diagnosis	ALOS 1979	ALOS 1980	Days Saved
Baltimore City PSRO (MD)	Congestive heart failure	17.7	16.2	735
West Virginia Medical Institute	A.M.I.	18.1	16.7	455
Colonial Virginia FMC	A.M.I.	17.7	15.6	200
	Diabetes	14.5	10.5	40
	Ischemic heart disease	6.9	6.5	16
	Pneumonia	7.1	5.3	18
Piedmont Medical Foundation (NC)	A.M.I.	15.4	15.2	174
	Pneumonia	16.3	14.6	119
North Central Medical Peer Review Foundation (NC)	Adult diabetes	10.4	10.3	180
Central Piedmont PSRO (NC)	C.V.A.	13.5	11.6	184
West Central Florida PSRO	Diabetes	11.5	9.5	874
Virgin Islands Medical Institute PSRO	C.V.A.	23.7	12.4	1,130
	Pneumonia	11.9	11.1	48
CENTRAL				
Region Six PRO (OH)	Cerebrovascular disease	12.6	12.0	625
	A.M.I.	15.5	12.2	1,980
Western Michigan PSRO	Pneumonia	13.2	10.4	560
East Central Illinois FHC	Diabetes Mellitus	10.6	9.1	1,223
	Chronic Ischemic heart disease	9.6	8.5	1,169
	Cerebrovascular disease	11.5	10.5	2,370
	Heart failure	12.2	9.7	3,810
	Pneumonia	10.5	10.1	493
	A.M.I.	13.2	12.4	708
Blackhawk Area Health Care Review Org. (IL)	Pneumonia	9.2	9.0	118
Indiana Area III PSRO	Chronic ischemic heart disease	11.8	10.9	460
Kansas FMC	Diabetes	9.9	8.4	2,154
WEST				
Greater Southern Arizona PSRO	Pneumonia	17.2	13.1	103
	C.V.A.	15.6	13.7	380
Multnomah FMC (OR)	C.V.A.	12.3	10.3	1,956
Area XXII PSRO (CA)	Diabetes	11.1	8.8	1,888

Reductions in pre-operative length of stay. Twenty-six PSROs found and corrected problems in excessive lengths of stay for pre-operative procedures, resulting in a reduction of 69,678 days for a savings of $5,636,253.

Table 7: Reductions in Preoperative Length of Stay (LOS) by PSRO and Region of the Country

Region and PSRO	Procedure	Pre-op LOS 1979	Pre-op LOS 1980	Days Saved
NORTHEAST				
Connecticut Area II PSRO	T.U.R.P.	4.3	3.6	350
Rhode Island PSRO	Cataracts	2.0	1.1	1,159
New York County Health Services Review	Vaginal hysterectomy	1.7	1.6	21
	Cholecystectomy	3.0	2.7	198
	Unilateral Inguinal hernia repair	1.5	1.4	179
	Arthroplasty of hip	3.5	2.1	941
	T.U.R.P.	3.4	3.1	417
	Suprapubic prostatectomy	3.5	3.0	134
	Blepharoplasty	1.1	1.0	53
Kings County Health Care Review Organization (NY)	Cholecystectomy	6.1	5.6	50
	Medicare elective surgery	4.0	2.5	15,000
	Medicaid elective surgery	2.1	1.0	22,000
Five County Organization for Medical Care and PSR (NY)	Unilateral inguinal hernia	2.1	1.7	30
	Intracapsular lens extraction	1.3	1.1	10
	Open reduction of fraction of femur	3.5	2.1	56
PSRO of Rockland (NY)	Herniorrhaphy	2.1	2.0	8
Nassau PRO (NY)	Elective surgery	1.7	1.4	3,000
PSRO of Queens County (NY)	Elective surgical admissions (Medicare)	3.5	2.2	7,476
	Elective surgical admissions (Medicaid)	1.3	1.0	1,725
Passaic Valley PSRO (NJ)	Cholecystectomy	3.5	2.5	201

Region and PSRO	Procedure	Pre-op LOS		Days Saved
		1979	1980	
Essex PRO (NJ)	Abdominal/vaginal hysterectomy	2.6	2.3	131
	Cholecystectomy	5.1	4.8	149
PSRO of Union County (NJ)	Vaginal hysterectomy	1.5	1.4	6
	Unilateral repair of inguinal hernia	1.8	1.6	39
	Gastroscopy	1.6	1.4	46
	Diagnostic D & C	1.8	1.2	136
	Unilateral extended simple mastectomy	3.0	2.3	71
	Insertion of temporary cardiac pacemaker	4.2	2.3	177
	Appendectomy	1.4	0.9	35
Southwestern Pennsylvania PSRO	Cataract removal	1.4	1.2	194
Southcentral Pennsylvania PSRO	T.U.R.P.	3.8	3.5	440
SOUTH				
Delaware Review Org.	Elective surgery	4.7	2.7	1,530
West Virginia Medical Institute	Cholecystectomy	5.8	5.3	100
	Inguinofemoral herniorrhaphy	2.2	1.8	80
	Intracapsular lens extraction	1.7	1.3	160
	Arthroplasty	4.3	3.1	240
	T.U.R.P.	5.0	4.1	90
Colonial Virginia FMC	Complex or radical mastectomy	4.4	3.3	33
	Hysterectomy	2.4	1.9	44
	Cholecystectomy	5.4	5.2	60
	Inguinofemoral herniorrhaphy	2.0	1.8	38
	Intracapsular lens extraction	2.0	1.6	40
Piedmont Medical Foundation (NC)	Cholecystectomy	2.6	2.4	67
	High pre-op LOS all procedures	2.9	2.5	6,000
CENTRAL				
Region VI Peer Review Corporation (OH)	T.U.R.P.	5.0	4.6	180
Western Michigan PSRO	Lens extraction	3.3	1.0	1,840
	Hip fracture	8.0	4.0	760
Iowa FMC	T.U.R.P.	4.0	3.6	960
	Intracapsular lens extraction	1.4	1.3	450
	Cholecystectomy	3.7	3.5	420
Kansas FMC	T.U.R.P.	4.3	4.0	556
	Amputation of lower limb	9.7	9.2	201
WEST				
Greater Southern Arizona PSRO	Pre-op LOS – Medicare	3.5	3.4	360
Mid-Peninsula PSRO (CA)	Carotid artery stenosis & occlusion	2.2	1.4	24
Superior California PSRO	T.U.R.P.	1.8	1.7	55
	Total hip arthroplasty	2.4	1.4	120
Riverside County PSRO (CA)	Total replacement	2.2	1.3	34
	Cholecystectomy	3.3	2.8	520
San Francisco PRO (CA)	T.U.R.P.	2.8	2.4	266

IMPROVING QUALITY

Eighty-five PSROs reported on 357 instances of PSRO action leading to improvements in the quality of patient care. These quality improvements spanned the spectrum of possibilities including improved performance of individual physicians and other health care practitioners, correction of institution-wide or areawide problems, elimination of unjustifiable surgical procedures, reduction in mortality rates, improved use of medications, increased appropriateness in the use of ancillary services plus much more.

The tremendous volume of activity reported precludes inclusion here of all examples. A few have been chosen, however, to show the broad range of PSRO accomplishments in improving the quality of health care services provided to the American public.

Acute Myocardial Infarction. Alabama Medical Review, Inc., the PSRO for the entire state of Alabama, found unacceptably high acute myocardial infarction mortality rates in thirty hospitals in the state due to delays in placing patients on cardiac monitors and to delays in starting IVs. PSRO physicians met with their peers to discuss these problems and arranged for inservice training and continuing medical education efforts. A follow-up audit documented a 71% improvement in timely placement of patients on cardiac monitors and a 62% improvement in the expeditious administration of IVs.

The Central Piedmont PSRO located in Durham, North Carolina found that the mortality rate for acute myocardial infarction (AMI) patients in one area hospital was 46.7%, a rate deemed much too high by the physicians. As a result, PSRO physicians met with their peers at that hospital, discussed the problems uncovered, and arranged for medical education on AMIs. One year later, analyses showed that the mortality rate for AMI in that hospital had been reduced by 37%.

The Region III Professional Review Organization in Findlay, Ohio identified a 67% mortality rate for AMI patients in one area hospital. The PSRO physicians met with the hospital chief of staff to discuss appropriate treatment methods as well as contraindicated treatment. In addition, due to the size and resources of the institution it was recommended that serious cases be considered for transfer to nearby facilities better equipped to handle them. The PSRO reported that the AMI mortality rate dropped from 67% to 0% with serious cases being transferred to a nearby coronary care unit.

The Kern County PSRO located in Bakersfield, California reported high incidences of mortality in four area hospitals following myocardial infarctions. Further investigation showed that two of these hospitals did not have sufficient resources to provide adequate backup for MI patients. 100% non-delegated concurrent review in these two facilities provides for transfer of stabilized MI patients to speciality units in other hospitals and has resulted in reductions in mortality rate of 83% and 50% respectively for these two hospitals. Medical staff in the remaining two hospitals have examined treatment regimens for MI patients and have corrected problems leading to MI mortality reductions of 14% and 30% respectively.

Use of blood. The West Virginia Medical Institute, the statewide PSRO located in Charleston, identified a problem in wastage of blood and blood ordering practices for surgical procedures and/or inefficient blood bank practices. 327 physicians, Blood Bank and laboratory personnel were involved and 24,680 federal patients were affected annually.

Working closely with the American Red Cross Blood Services (ARCBS) the PSRO compared actual ordering and transfusing practices to current acceptable ARCBS standards and implemented corrective action where indicated. The ARCBS covering West Virginia reports a decrease in blood wastage from 10% to 6.7% following the study. Given that the net distribution of blood for this area was 44,790 units at a cost of $39/unit, the decrease wastage has resulted in savings of $62,568.

Ohio Area XI Physicians Peer Review Organization located in Ashland, Ohio found an overuse of the test type and crossmatch in twenty-four facilities affecting 8,000 patients. The PSRO informed staff of each hospital of the current blood utilization procedures recommended by the Red Cross and placed seven of the 58 involved physicians under concurrent review to improve blood utilization techniques. Results show that appropriate replacement of the type and crossmatch by the type and screen has occurred in 50% of the cases. Since the average type and crossmatch costs $40.00 while the average type and screen costs only $7.00, the PSRO estimates savings at $132,000.

The Rhode Island PSRO in Providence found inappropriate administration of single unit transfusions in one hospital affecting 220 patients. Based upon direction of the PSRO, in-house educational sessions were conducted in the Department of Anesthesia, the Department of Nursing and among the Chiefs of Service. A reaudit showed that inappropriate single unit transfusions for non-surgical and intra-op patients were reduced by 100% and inappropriate post-op single unit transfusions were reduced by 60%.

Physician behavior. The Southwestern Pennsylvania PSRO located in Greensburg identified one general surgeon who was treating a large number of medical service cases in a manner his peers judged inconsistent with good quality. In examining the denial letters issued at the hospital in which this physician practiced, it was found that 24% of the denials for the entire hospital were attributable to this single physician.

The PSRO physicians made several attempts during 1980 to work with the general surgeon to correct the identified problems, but the general surgeon refused to change his pattern of practice. The PSRO, was, therefore, left with no alternative but to file a sanction recommending exclusion of this physician from receiving Medicare and Medicaid payment for services. A decision by the Secretary on that sanction is still pending with the Department of Health and Human Services.

Physicians in the Riverside County PSRO located in Riverside, California identified one internist who was providing inadequate medical care. A conference was held by PSRO physicians with the internist to discuss these problems and pre-admission certification review was instituted on this internist's patients. Concurrent review of this internist's practice was implemented and showed dramatic improvement in all problem areas.

The Nassau Physicians Review Organization in Westbury, New York discovered one physician who, in the judgement of his peers, was providing poor quality geriatric care. Physicians from the PSRO met with this physician to discuss problems and recommend necessary changes. Failure to correct the problems led to placing this physician on concurrent review and second opinion consultation. Ultimately, the refusal of this physician to change his inappropriate practice patterns left his peers with no choice but to recommend to the Department of Health and Human Services that this physician be excluded from participation in the Medicare and Medicaid programs. A decision is still pending.

The San Francisco Peer Review Organization identified one physician who, according to the judgement of his peers, was providing substandard quality care to patients in three acute hospitals. Physicians from the PSRO met with the physician in question and discussed the areas in which his practice was deficient. Failure to correct problems led one hospital to dismiss the physician from its staff. The physician has been placed on second opinion consultation in the two remaining hospitals and in one of these institutions the physician's operating room privileges have been restricted. The physician's services are also subject to a special condition of payment, that is, all surgery he performs is reviewed by the hospital Chief of Surgery with monthly reports sent to the hospital quality assurance committee and quarterly reports to the PSRO. To date, surgeries performed since this action was taken have been acceptable, however, the special condition will remain in effect for the present time to assure that the improvements are enduring.

Physicians in the San Joaquin Area PSRO located in Stockton, California found one physician who was providing poor quality care in both the acute and the long-term care settings. A peer review conference of physicians from the PSRO was held with the physician in question to discuss inappropriate practice patterns. A letter was then mailed to the physician detailing specific recommendations for correction in medical practice. The physician was also placed on preadmission certification and concurrent review was intensified. Following the physician's failure to correct his problems, the PSRO recommended to the Department of Health and Human Services that this practitioner be excluded from participating in Medicare and Medicaid. This action was granted and the physician has been suspended for five years from the Medicare and Medicaid programs.

The Kentucky Peer Review Organization identified one physician practicing poor quality medicine and having a high rate of unjustified admissions to hospitals. At the PSRO's urging, this physician attended medical education courses on various topics in which he had demonstrated deficiencies. The physician also hired a young associate to assist him in his practice. Follow-up monitoring of the physician's practice shows improvements in the quality of care and decline in unjustified admissions.

The Colonial Virginia Foundation for Medical Care located in Virginia Beach identified deficiencies in the practice patterns of twenty-six physicians in the PSRO's area. Monitoring reports were sent to the hospitals in which these physicians practiced with requests for review and comment by those involved. Special chart monitorings of these physicians' cases were conducted. Discussions of deficiencies with the involved physicians were conducted. Concurrent review of these twenty-six physicians was intensified. Results show that twenty-four of the twenty-six physicians demonstrated improved care. The two physicians who did not demonstrate improvement are under continued monitoring.

Other quality improvements. The Eastern Massachusetts PSRO located in Cambridge found that one hospital was inadequately prepared to conduct resuscitative efforts on children due to lack of proper equipment and lack of adequately trained personnel. A conference was held with this hospital during which proper procedures and equipment needs were discussed. The hospital purchased a new pediatric monitor. Training took the form of calling mock codes to which teams were to respond as if pediatric resuscitative efforts were needed. As a result of these actions, a test showed that the new pediatric code box containing all needed equipment was at the required site fully equipped. All personnel responses were appropriate and documented. The code team at this hospital is now fully capable of and prepared to conduct successful pediatric resuscitative efforts.

The Foundation for Health Care Evaluation in Minneapolis, Minnesota found poor quality of care in two hospitals in the treatment of hysterectomy patients. Physicians and nurses from the PSRO met with their peers in these two hospitals to discuss the problem areas and necessary corrective actions. A follow-up audit showed an 88% reduction in the incidence of urinary tract injuries, a 24% reduction in the incidence of primary hemorrhage and a 91% reduction in the incidence of urinary tract infections.

Medical Utilization Review of Southern Illinois, the PSRO located in Fairview Heights, found that in 38 facilities in its area there was a lack of appropriate discharge planning involving all actively practicing physicians, all nurses involved in post-hospital care and all social service personnel involved in planning post-hospital care. Physicians and nurses from the PSRO conducted workshops on discharge planning for those involved. The PSRO implemented a "Discharge

Planning Notification System" which is a standardized, mandatory discharge planning system. As a result, the number of hospital days spent awaiting placement in skilled nursing facilities was reduced by 40%.

The Iowa Foundation for Medical Care found excessive in-patient dental extractions being performed. All physicians and hospitals involved received written correspondence documenting the problems. Pre-admission certification was implemented for dental extraction admissions. As a result, in-patient dental surgeries were reduced by 95%.

The Foundation for Medical Care Evaluation of Southeastern Wisconsin found that 6.5% of the x-rays taken in its area were repeat x-rays. The PSRO collected and analyzed information to determine the cause of these retakes and then implemented corrective action to reduce the number of x-ray retakes. The result was a 33% reduction in the number of repeat x-rays. Over a one-year period this translates into a reduction of over 85,000 x-rays for an estimated cost savings of more than $1.2 million. In addition, radiation exposure from the unnecessary x-rays has been reduced.

The Multnomah Foundation for Medical Care located in Portland, Oregon reported that it had identified inappropriate emergency room use of skull radiography for head trauma. A conference was held with the radiologists and emergency room physicians to discuss the problem and to review the standards established for screening criteria. A follow-up evaluation showed a 30% decrease in the incidence of skull radiography for head trauma. Since the cost of skull radiography in the emergency room averages $56 per x-ray, this decreased use produced direct savings.

OTHER IMPACT

PSROs have also identified and corrected utilization and quality problems in areas other than reported above. A brief summary of that activity is as follows:

- Forty-eight PSROs reported correcting 94 problems associated with inappropriate use of ancillary services.
- Twenty-eight PSROs reported correcting 83 problems in long-term care facilities.
- Five PSROs reported eleven improvements in the delivery of ambulatory care services.
- Nine PSROs reported reductions in numbers of admissions to hospitals.
- Seven PSROs reported reductions in admissions/1,000 Medicare or Medicaid beneficiaries.

CONCLUSION

As shown by the examples reported on the previous pages, PSROs are meeting the challenge of reducing unnecessary and inappropriate utilization while improving the quality of health care services. Although the majority of PSRO utilization activities are focused on the care provided to Medicare and Medicaid patients, more and more private industries are contracting with PSROs to review care provided to their own employees.

A survey conducted in October of 1981, to which 116 PSROs responded, showed that 42 of these PSROs had contracts with the private sector to conduct review. In addition, fifteen PSROs reported that they are in the process of negotiating such contracts. This increasing activity in the private sector is another strong indication that PSROs are demonstrating their abilities to assess and improve the manner in which health care services are delivered in this country.

Table 1: Overall Average Length of Stay Reductions in Medicare by PSRO

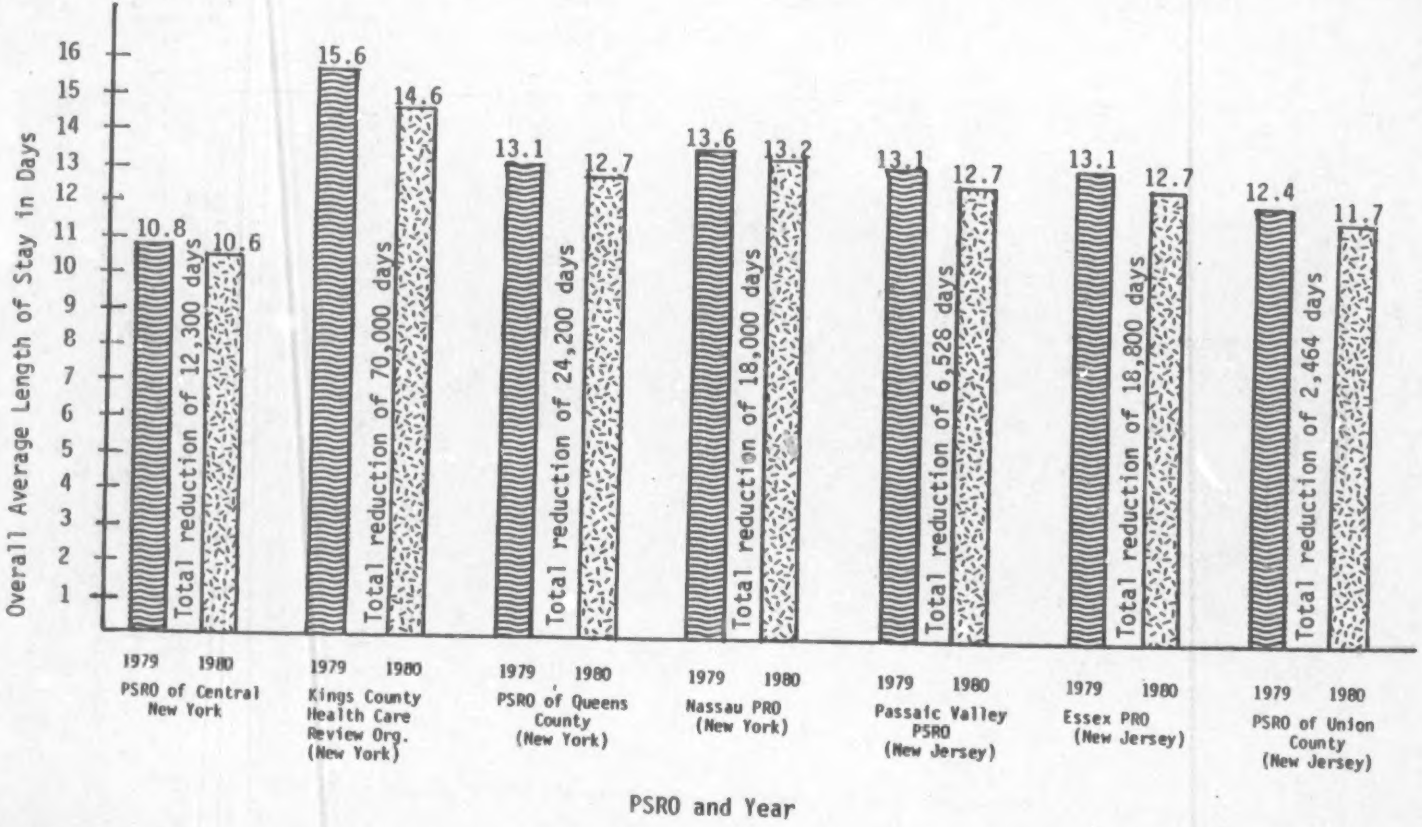


Table 1 (cont'd): Overall Average Length of Stay Reductions in Medicare by PSRO

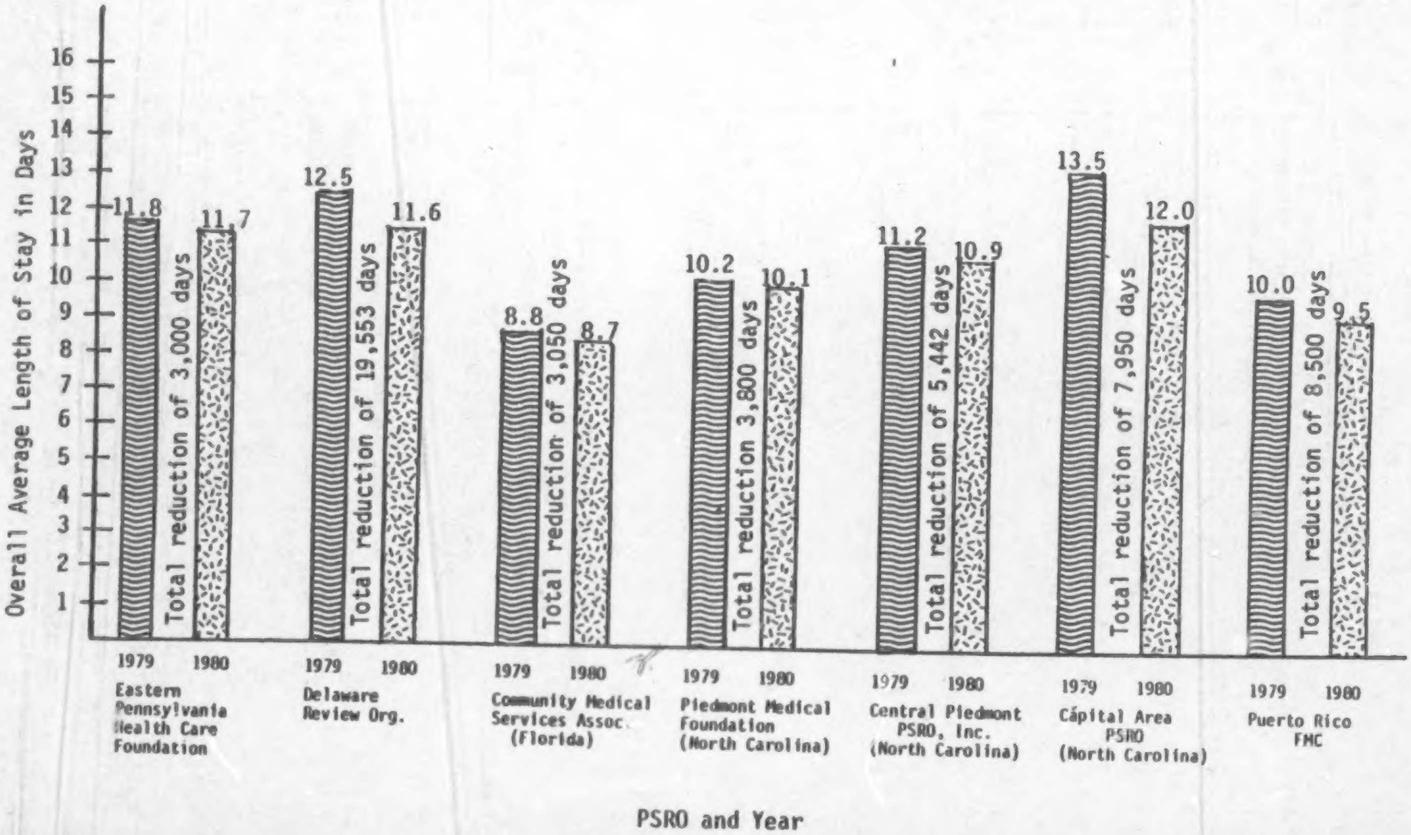


Table 1 (cont'd): Overall Average Length of Reductions in Medicare by PSRO

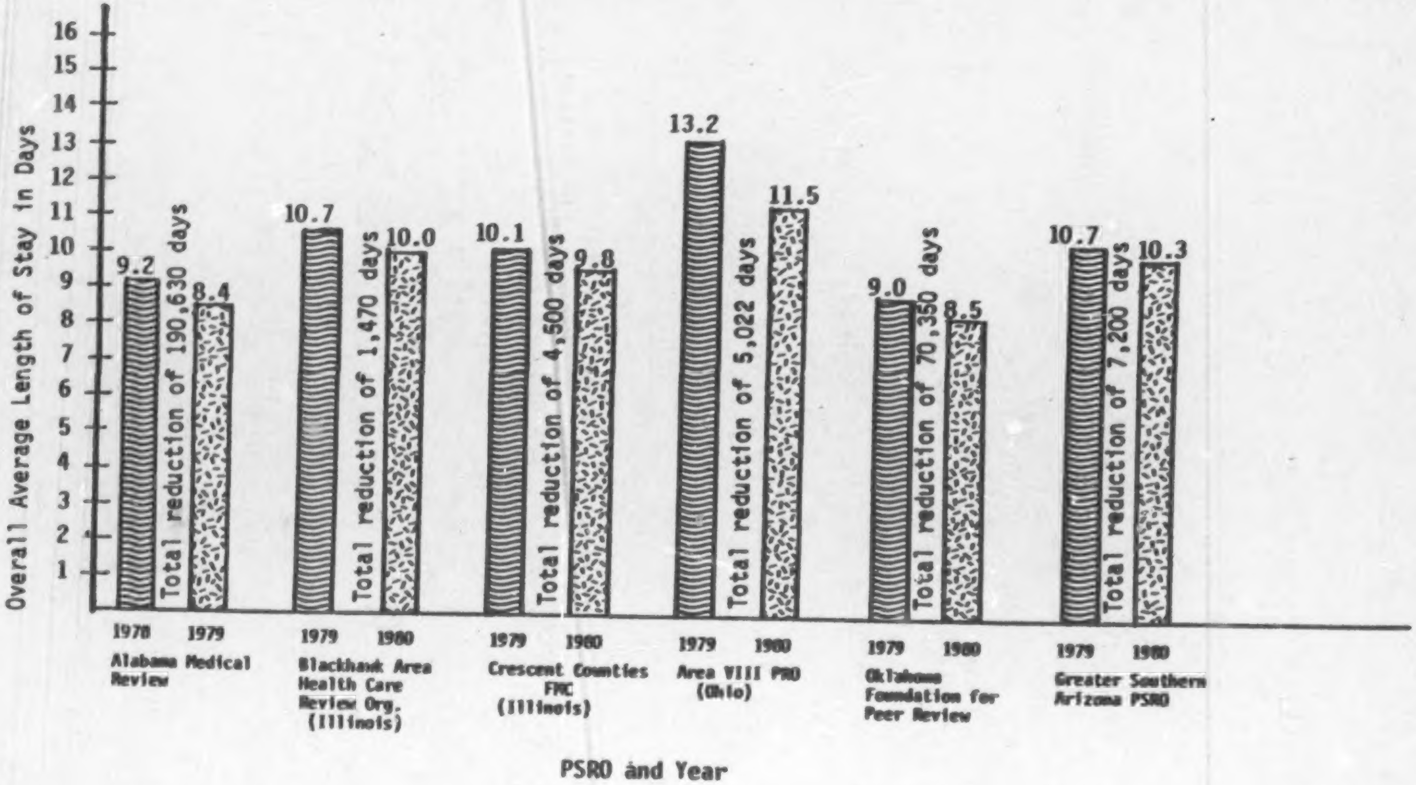


Table 1 (cont'd): Overall Average Length of Stay Reductions in Medicare by PSRO

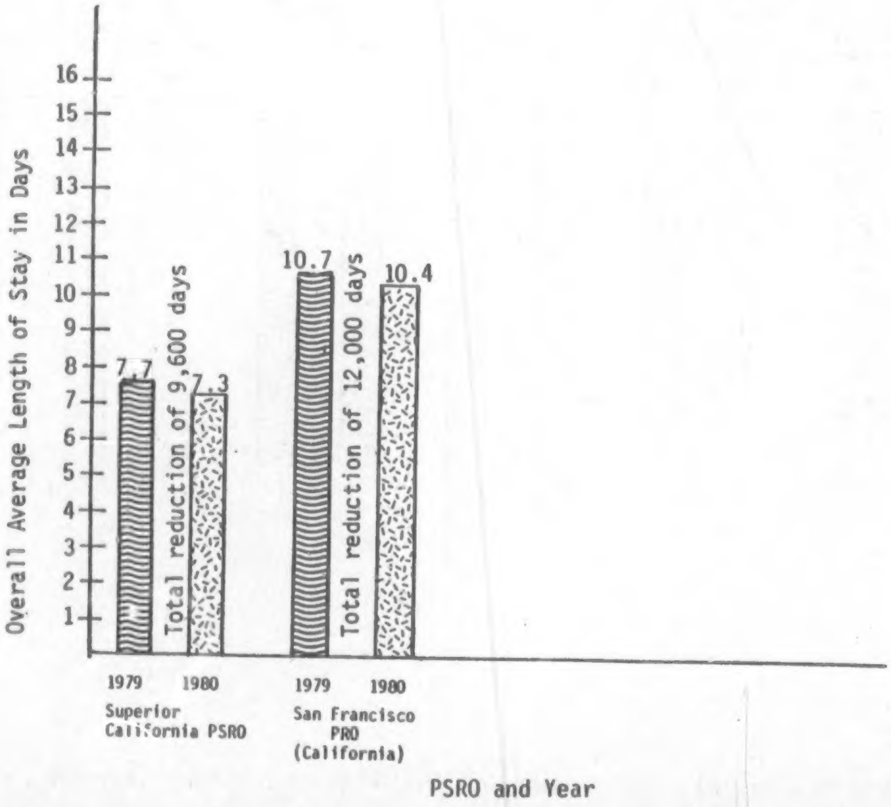


Table 2: Overall Average Length of Stay Reductions in Medicaid by PSRO

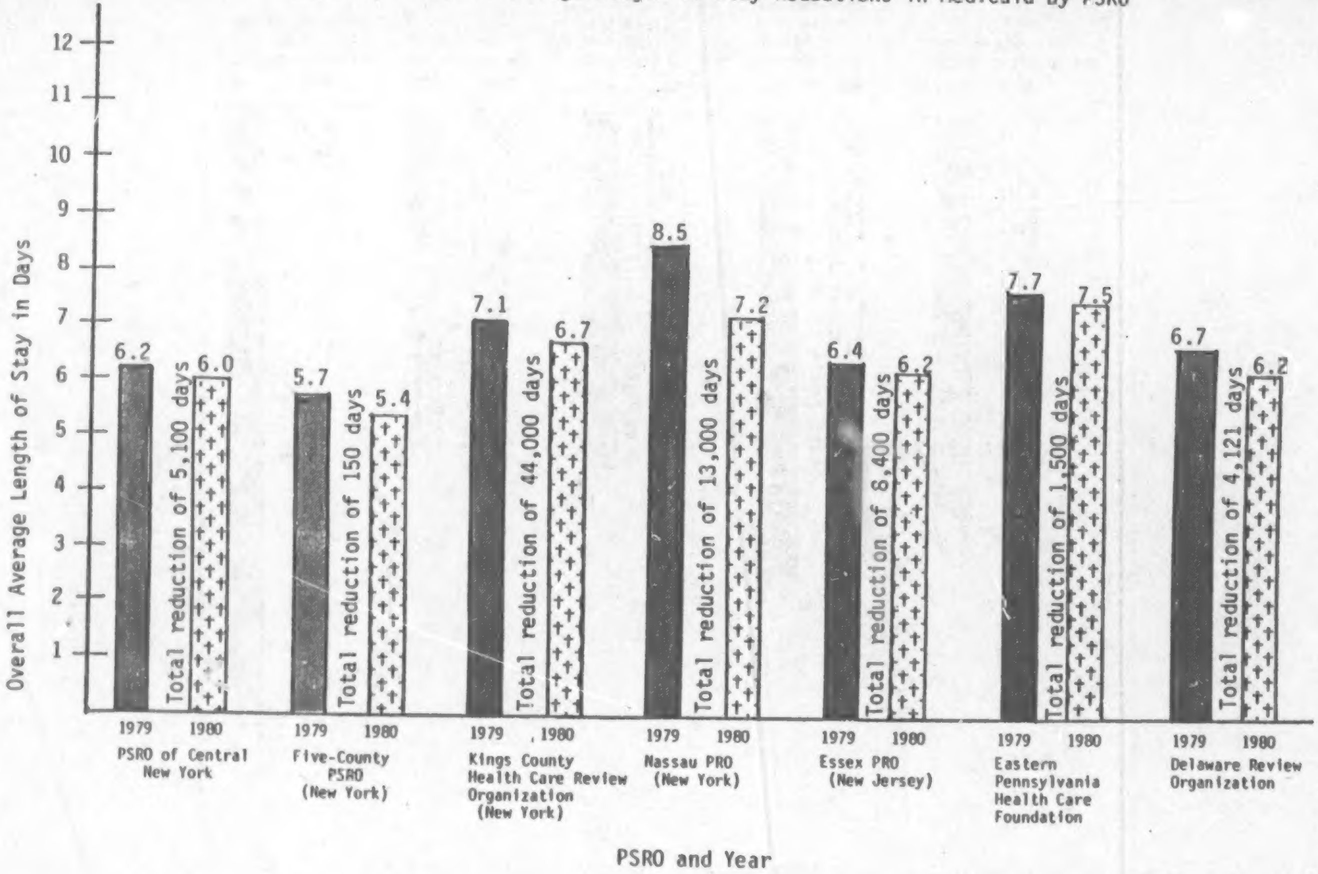


Table 2 (cont'd): Overall Average Length of Stay Reductions in Medicaid by PSRO

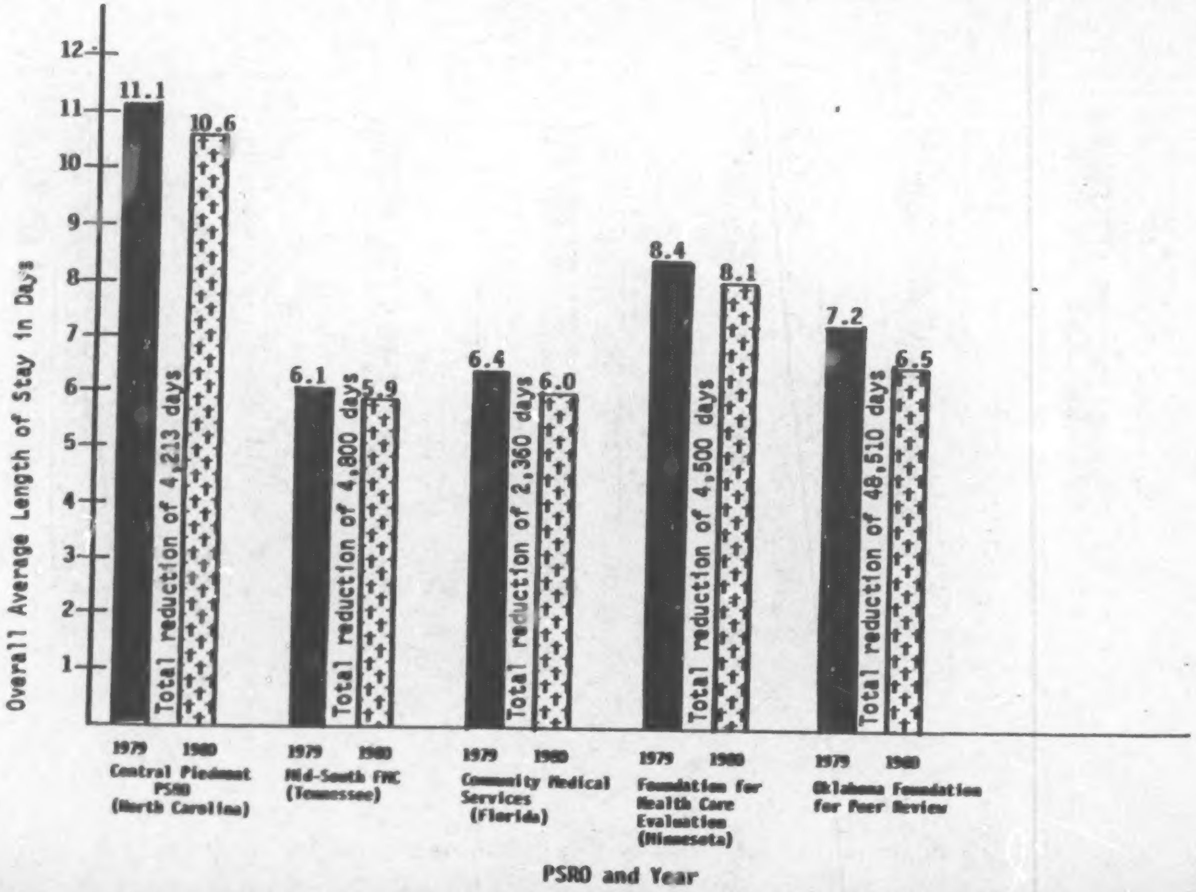


Table 3: Reductions in Days of Care/1,000 Medicare Eligibles by PSRO

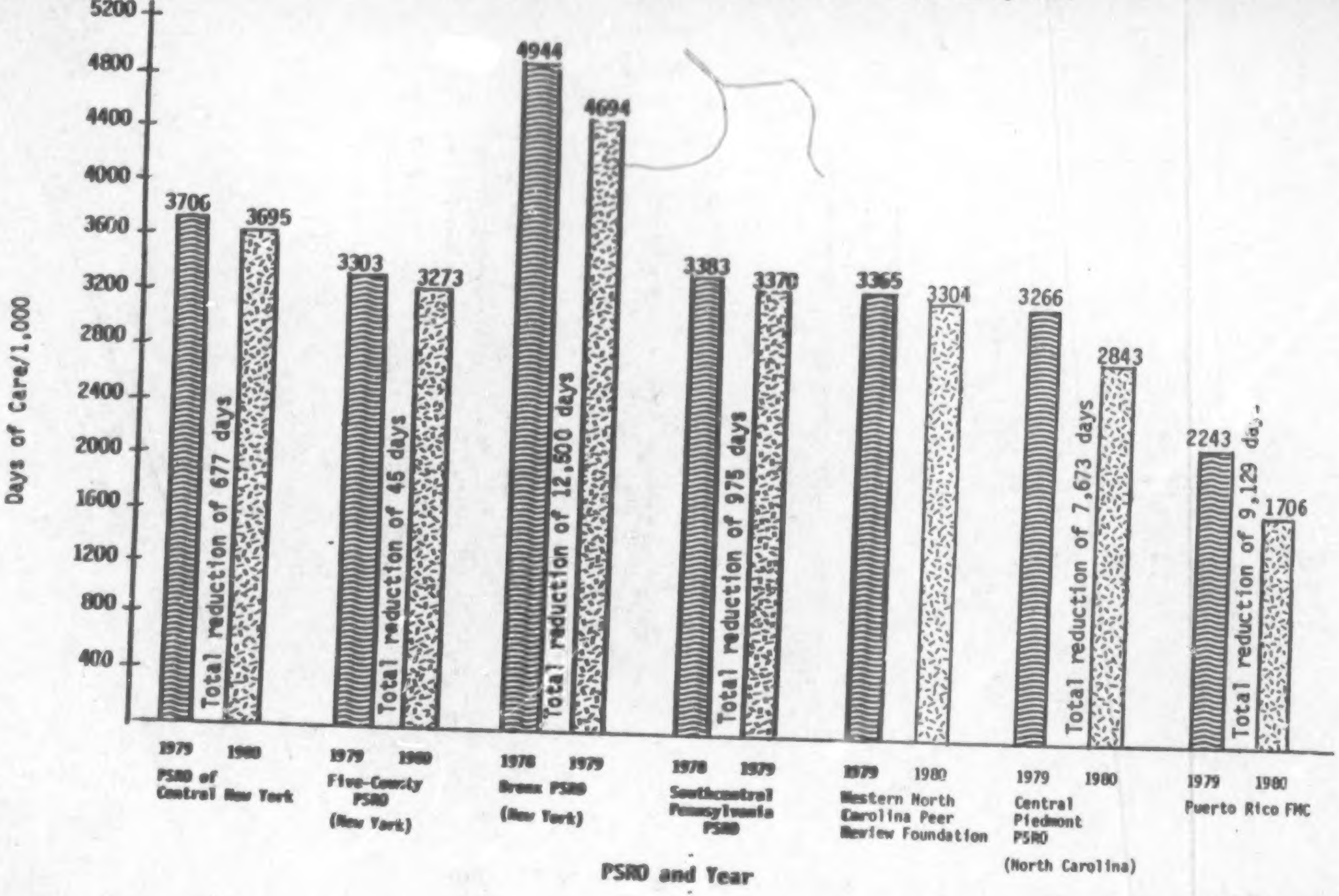


Table 3 (cont'd): Reductions in Days of Care/1,000 Medicare Eligibles by PSRO

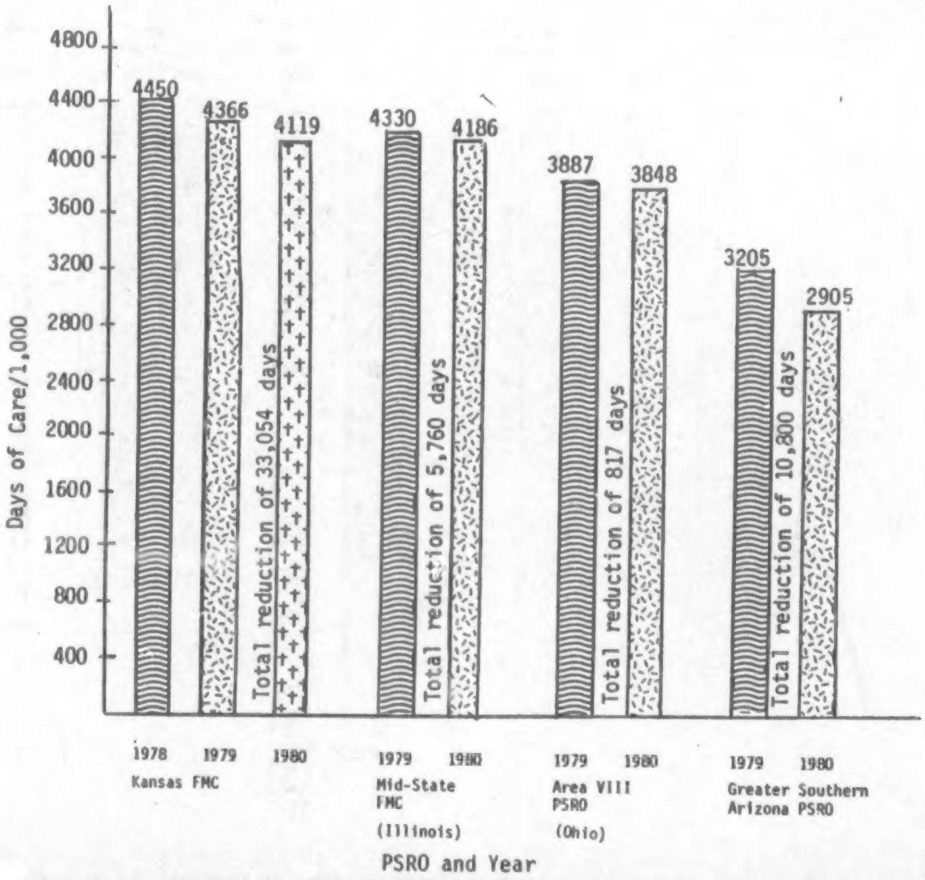
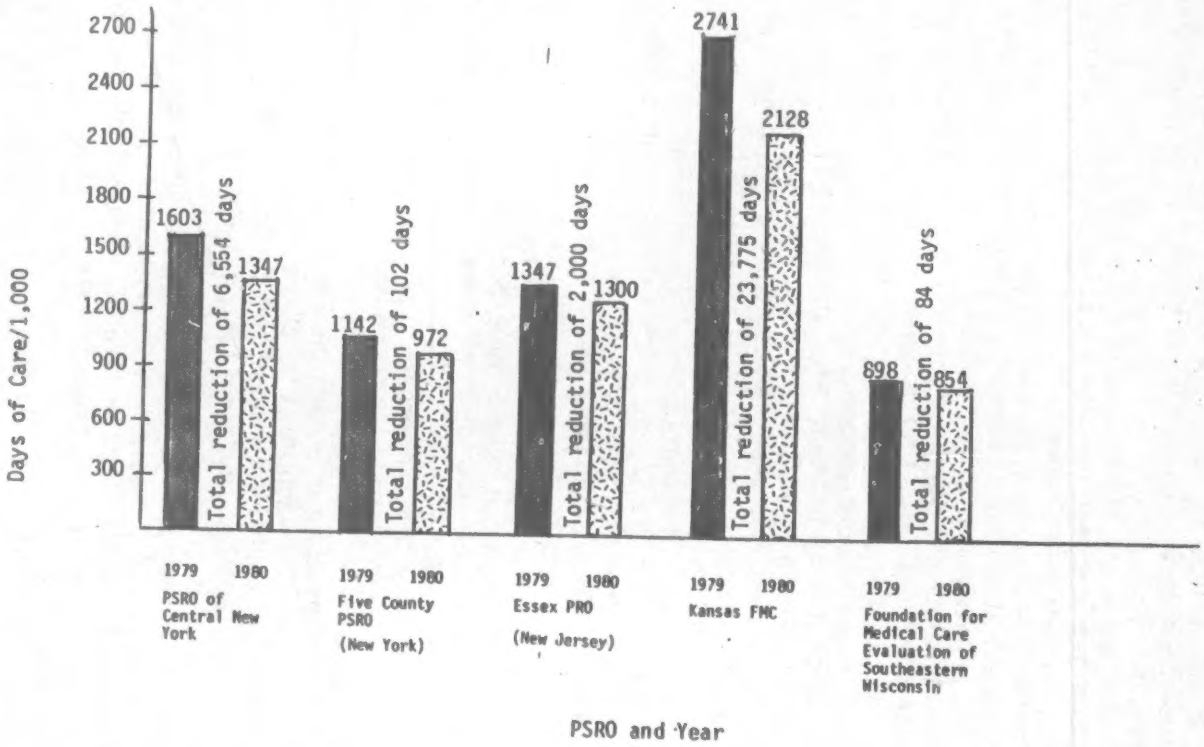


Table 4: Reductions in Days of Care/1,000 Medicaid Eligibles by PSRO



Senator **Durenberger**. Thank you very much.

Dr. Sunderbruch, in your view should insurance companies and hospitals be able to compete for contracts if no physicians groups are available?

Dr. **Sunderbruch**. By all means. I think the physicians should be first, and in my experience when it is left to other than physicians' review, it is not a profitable procedure.

Senator **Durenberger**. How do we get physicians who might subscribe to the Ron Paul theory of government involvement in medical care to participate in peer review?

Dr. **Sunderbruch**. Well, I suppose I cannot answer that too well because I did not have that problem in Iowa. It took us over 1½ years to sell the bill, even getting by the Union of Physicians, going through a vote process, but we accomplished the mission. And I think it is up to the medical profession to sell the bill.

Now maybe others at this table have other experiences in other areas that have other answers than that, but I think it is the job of the physicians to sell their constituency to get this job done.

Senator **Durenberger**. Dr. Weeks, how would you react to the question of how to get more physicians involved?

Dr. **Weeks**. It helps if you involve the nursing profession at this point. I have had this problem. In my own PSRO I have my share of rednecks. The easiest way to do it is to get them on a review panel or get them to go out and assess a hospital, level with you and simply get involved. I would say today that some of my most conservative physicians who have become involved actually look upon this as a challenge to save Federal bucks, and are some of my toughest reviewers.

So it will work if you approach it with a little commonsense.

Senator **Durenberger**. Mr. Thompson?

Mr. **Thompson**. Senator, I think also we have to realize physicians do not practice in a vacuum. They do not approach these peer review issues in a vacuum. One of the most exciting happenings is the advent of coalitions around the country. When a group of employers get together representing a big segment of the private patient load in the area and sit down with the medical profession and suggest that they should do something, it helps the medical profession to zero in on starting a peer review organization.

Senator **Durenberger**. Dr. Weeks, speaking of not practicing in a vacuum, I take it you have a private practice?

Dr. **Weeks**. Yes, sir.

Senator **Durenberger**. Do you associate with other physicians in that practice?

Dr. **Weeks**. Four other physicians.

Senator **Durenberger**. Is that a not-for-profit practice?

Dr. **Weeks**. Well, no; we work for a living. We share a lot of our profits with other people.

Senator **Durenberger**. There is some motivation in your business besides the healing part of your profession, then?

Dr. **Weeks**. Yes.

Senator **Durenberger**. Why is it then that you object to a for-profit organization being involved in peer review?

Dr. **Weeks**. I beg your pardon?

Senator **Durenberger**. Why do you object to a for-profit organization contracting for peer review?

Dr. **Weeks**. I do not know that I personally would exclude this totally in all circumstances. I think those who look upon this device as a for-profit business set themselves aside as being suspect. In other words, I have talked frankly with my board of trustees about the possibility that if PSRO goes down the tubes, let us set up for profit.

Senator **Durenberger**. But that is sort of a malady that this whole country has been suffering from, the idea that if public services are delivered for a profit, somebody must be ripping off the public. And if we could find a way to turn that disease into some sort of a positive, are there any basic reasons why the profit part of an organization would do violence to peer review?

Dr. **Weeks**. I think in general you have better PR if you are nonprofit. I think if the checks and balances are proper, these organizations could be for profit. I would not recommend it, based on my own experience in dealing with the third parties and so forth.

On the other hand, I have had tough businessmen say why do you not do this for a living? If you are half as good as you say you are, you could live off this.

Senator **Durenberger**. I am glad you got that into the record. Thank you.

Senator Baucus.

Senator **Baucus**. Yes, I am curious as to what your reaction is to the administration's statement earlier that 10 percent of hospital care today is unnecessary. Do you agree with that statement?

Dr. **Weeks**. I do not know what percentage to put on it. Certainly a good percentage of admissions are unnecessary from our point of view. You run into diagnostic admissions and so forth that can be done on an outpatient basis without involving inpatient care, et cetera.

In my State it is a curious phenomenon. I am dealing with four generations of people who have lived off the UMW welfare funds and a very strong welfare program in our State, and we are reestablishing some social norms. They go to the hospital for every social need that they have, and have for years and years. And we are slowly and quietly offsetting this.

So I would say that there is some validity to the 10-percent figure. I do not know exactly how high to pitch it.

Senator **Baucus**. It is your view that PSRO's generally, that is generally the present system is the best way to work at that problem?

Dr. **Weeks**. I do and I will tell you why. I deal with a number of very small, rural hospitals where there are anywhere from three to seven doctors on staff. These physicians know very well what the problems are relating to utilization and medical necessity and so forth. They cannot, living in their small communities, function in the way that they would like to. And simply by having an external group of doctors that they can communicate with and use as an excuse to carry out their own desires makes some very significant changes on a local community. And I have seen reductions in hospital admissions as high as 50 percent because of this.

Senator **Baucus**. Would that argument, though, carry even further if there is not a PSRO reviewing hospital utilization but rather a national insurance company?

Dr. **Weeks**. Well, let us face it. The physicians were burned early in the medicare program by the role that the FI has played in my State.

Senator **Baucus**. The role that the——

Dr. **Weeks**. The fiscal intermediaries have played. They were ineffective. They were unfair. They were very judgmental in the wrong fashion and they did not involve the broad spectrum of physicians. And I think the record will show this, for those of you familiar with things at that time. And the doctors are not going to react or interact with the private insurance company like they do with nonprofit physician organizations. It does not happen.

Senator **Baucus**. So you are saying that the PSRO system is a good balance.

Dr. **Weeks**. It is a balance in a very delicate political situation. I think you have to realize that.

Senator **Baucus**. Thank you very much.

Dr. Sunderbruch, do you have any contrary views or do you agree with the answers of Dr. Weeks?

Dr. **Sunderbruch**. No, we have had very fine experience. We have had a very different experience perhaps in Iowa, that we have done review for the Blues, for instance, and for the medicare and medicaid as an organization, and we have definitely decreased admissions and we definitely can prove in dollars and cents what we have saved.

Senator **Durenberger**. Thank you very much.

Chairman Dole.

Senator **Dole**. No; I have no questions but I have a statement to put in the record and I thank both witnesses and those who accompany the witnesses. We do have a monumental problem in trying to get a handle on health care costs. Without getting into all the horror stories, I think that next to our budget and the Soviet Union's, health care costs are larger than any budget for any country in the world. And to say that we cannot contain those costs I think is ignoring the problem.

This is one approach but we have some other more direct approaches we hope to pursue later this month. We are going to have to make some hard decisions, and medicare, medicaid in reimbursement of physicians, reimbursement of hospitals, limits on 223 and a number of other areas that we hope will have the unanimous support of those in the health care field.

Having now obtained that, I will stop. [Laughter.]

Senator **Durenberger**. I will just conclude with another observation. Clearly there is a stated preference here for physician-based review, but I guess we have to emphasize the point that the threat of nonphysician review may be necessary to get the physician to do a good job. In other words, I do not know that we should limit the review to physician organizations as a way to encourage them to participate in the process.

I thank both of you gentlemen and your organizations for very good presentations.

[The prepared statement of Harry S. Weeks, Jr., M.D., follows:]

TESTIMONY OF THE
AMERICAN ASSOCIATION OF
PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

PRESENTED BY

HARRY S. WEEKS, JR., M.D.

Mr. Chairman, my name is Harry S. Weeks, Jr. I am a practicing physician from Wheeling, West Virginia, and past president of the American Association of Professional Standards Review Organizations.

With me today is Lyla Hernandez, executive director of AAPSRO. We very much appreciate your providing this opportunity to present our views on the legislation before your committee which would affect our members.

The PSRO program has probably come under closer scrutiny and analysis than any other program of its size in which the government invests its funds. I have myself testified before committees of the Congress more than five times in just the last three years. Moreover, the program has been the subject of evaluations and studies by two arms of the Congress, by the GOA and the CBO, by agencies in the executive branch which pay for health care, and by state government.

I would like now to review briefly for the Subcommittee the most recent data which indicate the level of performance of the existing 147 PSROs.

The latest Health Care Financing Administration (HCFA) evaluation found that PSROs save $21 million more for the federal government than they cost to operate. The Congressional Budget Office found that PSROs save $17 million more for the federal government than relevant program costs but went on to maintain that shifts in cost to private sector patients (which current law does not encourage PSROs to review) were enough to offset those savings.

We believe that PSROs should be evaluated and that the results of these evaluations should be used to determine the future of the program, not ignored or obfuscated when the results do not conform with desired outcomes. We think it is important to look at what the PSRO program is accomplishing.

To do so, data from two separate sources have been analyzed. First, we obtained data on PSRO impact on reducing Medicare and Medicaid average length of stay from reports compiled and published by the Health Care Financing Administration (HCFA). These data cover the two most recent years for which such information is available, 1978 and 1979. Second, AAPSRO obtained information from PSRO statistical reports.

The best measure for inpatient hospital utilization effectiveness is, of course, the number of days of hospital care per thousand beneficiaries. That measure is the most accurate reflection of impact because it takes into account both the average length of stay and the admission rate. The Kansas Foundation for Medical Care, for example, achieved a reduction of 613 days of care per thousand Medicaid eligibles which translates into 23,775 days saved. This was accomplished through intensive educational efforts directed at patients, physicians and hospitals.

Unfortunately, HCFA was not able to furnish us with data expressed in terms of days of care per thousand and we were forced to use length of stay information. However, we are confident that national data would show a high correlation between reductions in average length of stay and reductions in days of care per thousand.

Our analysis of data published by HCFA show that 70 PSROs in operation today were in full operation for hospital review and reporting on Medicare data in both 1978 and 1979.

The total reduction achieved by these PSROs through reducing Medicare length of hospital stay was 647,634 days. The American Hospital

Association estimated the cost of providing services per patient day in 1979 was $217.34. Rather than using 40% of this cost to estimate savings (as HCFA does when it evaluates PSRO), we used the even more conservative figure of 33%. The reduction in days achieved by these PSROs, then, converts to an estimated savings of $46,448,310 without allowing for any effect of PSROs in reducing admissions or reducing the use of ancillary services.

Data on Medicaid average length of stay is available for 62 PSROs in operation today and fully implemented and reporting on Medicaid during 1978 and 1979. These data show that these 62 PSROs achieved decreases in Medicaid stays totaling 249,480 days saved. Again, using 33% of the American Hospital Association's daily cost figure, we find that the reduction of days in Medicaid amounted to an estimated savings of $17,891,844 again without allowing for reductions in admissions or ancillary services. Thus, the total savings in 1979 program costs over 1978 amounted to at least $64 million.

In addition to the HCFA data, the American Association of Professional Standards Review Organizations collected data from the statistical files of PSROs for the years 1979 and 1980. We have prepared a report from these data which includes information on PSRO achievements in the areas of both utilization reduction and quality improvement. We have attached a copy of the report to our testimony.

Here are the basic results on PSRO impact during 1980 which are further illustrated and documented in the report.

- Eleven PSROs had information available on days of care per thousand Medicare beneficiaries. These PSROs reported reductions of 81,430 days or a savings of $6,586,873.

- An additional seventeen PSROs reported decreases in Medicare average length of stay totaling 465,095 days for an additional savings of $27,621,534.
- Five PSROs reported on reductions in Medicaid days of care per thousand beneficiaries amounting to a total reduction of 32,515 days for additional savings of $2,630,138.
- Nine other PSROs reported decreases in Medicaid lengths of stay totaling 127,004 days for another $10,273,353.
- An additional twenty-two PSROs reported achieving reductions in procedure-specific average lengths of stay amounting to a total of 14,662 days for added savings of $1,186,009.
- Twenty other PSROs reported achieving reductions in diagnosis-specific average lengths of stay totaling 25,962 days for additional savings of $2,100,066.

These reports, then, show that during 1980, 62 PSROs were able to achieve reductions amounting to savings of $60,397,973 through reductions in average length of stay and days of care per thousand beneficiaries alone.

And, of course, PSROs do not concentrate solely on reducing lengths of hospital stay or days of care per thousand. They also identify and correct problems in the quality of patient care. For example, the Central Piedmont PSRO, located in Durham, North Carolina, found that one hospital in its area had a mortality rate for acute myocardial infarction of 47% -- a rate judged much too high by the physicians in that PSRO.

PSRO physicians met with physicians in that hospital, discussed how such patients should be treated and pointed out problem areas. The PSRO then conducted on-site monitoring of patients admitted to that hospital with acute heart attacks to insure that appropriate changes were being implemented. The result -- an almost immediate reduction of 37% in the mortality rate.

PSROs also identify and eliminate unnecessary use of ancillary services -- an effect which is not measured by HCFA. The PSRO located in Milwaukee, Wisconsin, for example, learned from its data analysis that 6.5% of the hospital x-rays in its area were retakes even though this rate is below the national average (the average retake rate for the U.S. is 9% - 10%). They then investigated and determined the causes of these repeat x-rays, implemented corrective action designed to eliminate some of the causes and in a short time achieved over a 30% reduction in the retake rate. This 30% reduction means that more than 85,000 unnecessary x-rays were not taken.

At $15 per x-ray, this reduction translates into a cost savings of over $1,275,000 -- substantially more than the entire budget of that one PSRO for a full year. In addition, radiation exposure from the unnecessary x-rays has been reduced. The experience of this one PSRO is being made available to other PSROs interested in accomplishing similar reductions through the clearinghouse activities carried on by our Association -- not by HCFA.

Mr. Chairman, these are just a few of the examples of what PSROs have been able to accomplish. It is not only our data that show PSROs save more for Medicare than they cost the federal government to operate.

These same conclusions were reached by the Health Care Financing Administration and by the Congressional Budget Office.

In addition, the increasing number of private sector contracts with PSROs indicate that private business also views PSROs as a good investment. AAPSRO is nearing completion of a survey of PSRO private review activity which, when completed, will be shared with the Committee. To date, we have received 126 responses. The remaining twenty-six of the PSROs now in operation are being contacted by telephone. Of the 126 responses received so far, 67 PSROs have signed contracts for private review and an additional 18 are in the final stages of negotiating such contracts.

While we take no little satisfaction from being able to report these very positive accomplishments of the present program, we join Senators Durenberger, Heinz, Moynihan and Baucus in the belief that substantial changes should be made to improve the effectiveness of our efforts both for publically financed programs and private plans.

We see several important advantages in S.2142, the most far reaching bill before you. Perhaps foremost in the view of our members is the clear intent to avoid the detailed, day-to-day involvement of HHS employees in our work. The concept that we will negotiate a contract with the government and then be left to our own efforts and experience to meet the objectives set out in the contract will improve our ability to be more effective and efficient. We understand that our contracts would be monitored and that we would be required to abide by the contract in a responsible way. But that is a substantial improvement over the present situation where project officers can involve themselves in the day-to-day management of our work and change policies back and forth on a moment's notice.

We are also excited about the possibilities for substantially increased activity in private peer review which S.2142 will afford us. The provisions which refer directly to private review -- to require us to make our program available to private third-party payers and for the release of patient data for private review -- will be most helpful. We understand the intent of the provisions in Senator Baucus' bill S.1250 and in the Chairman's bill S.2142 to require that review organizations be based primarily at the state level is to produce administrative cost savings and facilitate private review by reducing the number of organizations with which private plans must negotiate contracts. However, in establishing these provisions we hope that nothing will be done to reduce existing PSROs which have the effectiveness of excellent records of achievement. In addition, the minimum number of hospital admissions set forth in S.2142 should reflect all admissions, not just Medicare admissions since the bill regulates organizations which will review all admissions.

We also support strongly the changes which S.2142 would make in the provisions under which a PSRO can recommend that a physician or hospital be subject to sanctions for delivering poor care. Our experience with the bureaucracy has been abysmal. Once a PSRO has reached the point of recommending a sanction you may be sure that the individual or organization involved is a very poor performer indeed -- that he is furnishing care of a substandard nature and has shown no interest in improving his performance. The history is that the Department takes years to act on these recommendations while the individual involved continues to harm patients. Obtaining prompt action from the Department on these cases is an absolute necessity. Moreover, we hope it will be made clear that nothing should prohibit a review organization from sending a copy of a recommended sanction to the state licensing authorities.

While we support the major provisions of S.2142 there are two or three changes which we would urge the Committee to make which we believe would result in more nearly accomplishing our mutual objectives.

First, we associate ourselves with the testimony of CIGNA that health insuring organizations themselves not be permitted to contract for peer review activities on the basis that such contracts would create a conflict-of-interest, anti-competitive situation. Blue Cross/Blue Shield and individual commercial health insurance companies, of course, compete among themselves for health insurance contracts. If one of them were to become a review organization, the requirement in the bill that it offer its services to other insurers would simply not be taken up by their competitors thus effectively removing the possibility of private review in that state.

We also would recommend that, when defining the requirement that a review organization is to be "composed of a substantial number of the licensed doctors of medicine" in an area, the word "substantial" be defined to mean a significant proportion of the physicians, on the order of at least 30 to 40 percent.

While we can appreciate and share in the objectives of increasing the potential numbers of organizations with which the Secretary could enter into contracts, our members are quite concerned that the prior requirement of non-profit status has been dropped. We are concerned that some organizations will spring up whose primary motivation will be their profits rather than improving the quality of care. We take considerable pride in the results of many of our efforts to improve quality whether or not reductions in cost may result. Many -- probably most -- of our peer review activities have the effect of improving quality and reducing costs. But we do some things to improve quality which may increase costs and we are proud of them. One example comes to mind. One of our members in North Carolina, when reviewing medical procedures in a psychiatric hospital, learned that patients were not routinely screened for heart disease or high blood pressure before the drug lithium was administered. Use of this drug is contraindicated in such patients since side-effects of the drug can lead to their deaths.

The PSRO worked with the hospital to establish a policy of screening and evaluation, including laboratory tests, for all patients who were candidates for this drug. PSRO physicians also established the criteria for deciding which patients could receive the drug. The result of this activity is a substantial improvement in the quality of care even though more tests and effort would be expended in the screening process. The point we wish to make is that an organization whose sole motivation is profit will not have incentives to concern itself with improving quality if the result could be higher program costs for which it might be penalized rather than rewarded.

Given the Administration's current recommendation that the PSRO program be repealed in favor of an as yet unknown substitute, we are understandably worried about whether the bill this Committee will approve would be administered in the spirit intended by its authors. In this sense we share some of the concerns expressed by Senator Baucus. We have quite frankly, no specific changes to suggest be made in the bill which we would have any confidence would influence an administrator to act responsibly to carry out the intent of Congress. We do believe, however, that if the Committee approves the legislation that it should obtain specific agreements from those now in the Department that they will administer the program in the manner intended. Such assurances might well be made part of the Committee's report to accompany the bill.

Mr. Chairman, we thank you for the Subcommittee's time and attention. We will be glad to answer any questions members of the Subcommittee may have.

Senator **Durenberger**. Our next panel consists of Mr. Duane Heinz, chairman of the board, Midwest Business Group on Health, Chicago, and manager of health care services for Deere & Co., of Moline, Ill.; Willis B. Goldbeck, executive director of the Washington Business Group on Health, Washington, D.C.; Mr. G. Robert O'Brien, senior vice president, Connecticut General Life Insurance Co., on behalf of the Health Insurance Association of America.

Welcome, gentlemen. We can go in the order you were introduced. Duane, you may proceed.

STATEMENT OF DUANE HEINTZ, CHAIRMAN OF THE BOARD, MIDWEST BUSINESS GROUP ON HEALTH, CHICAGO, ILL., AND MANAGER OF HEALTH CARE SERVICES, DEERE & CO., MOLINE, ILL.

Mr. **Heintz**. Mr. Chairman, members of the subcommittee, and distinguished guests, I am Duane Heintz, manager of health care services for Deere & Co., and chairman of the board of directors of the Midwest Business Group on Health.

I would like to thank you for extending this invitation to comment on the proposed Senate bill 2142, the Peer Review Improvement Act of 1982.

As 1 of nearly 80 member corporations within the 8-State Midwest Business Group on Health membership, Deere self-insures and self-administers a negotiated health care benefit plan for approximately 200,000 persons. We are vitally concerned with the general future of the health care delivery system and the potential impact this bill would have upon it. We applaud Senator Durenberger and the other sponsors of this bill in their effort to enhance the cost-effectiveness of the peer review concept and to maximize its potential efficiency through contract performance funding, as contrasted with the present categorical program funding basis.

The modifications that have been proposed reflect a substantial and necessary change in the relationship among peer review organizations, the Federal Government, and the private sector. The bill well recognizes the responsibility of the Federal Government as a major purchaser of health care services, and the requisite accountability for expending scarce taxpayer dollars only for medically necessary and appropriate quality health care services. We believe it represents one more positive step toward a competitive marketplace versus the traditional regulatory one.

MBGH, since its inception in 1980, has placed a very high priority on establishing private review programs to meet the needs of its corporate membership, who, like the Federal Government, serve a role as an aggregate purchaser of health care services, whether on a self-insured or insured basis. MBGH members have been instrumental in the establishment and/or expansion of private peer review programs throughout the State of Iowa, in Minneapolis, Minn., and Springfield, Peoria, Joliet, and Rock Island-Moline, Ill. Several additional projects are under development in Missouri, Michigan, Indiana, Illinois, and Ohio for implementation during 1982 and 1983. These initiatives have demonstrated a positive return on investment for member corporations of as much as 10 to 12 times.

We believe this magnitude of return may be realized by the Federal Government if it purchases review services from physician-based review organizations on a contract performance basis, as MBGH member companies have done for several years, and it actively supports the concept of review. We believe that the thrust of this bill is to build upon the lessons of experience found in the private sector.

Our collective experience suggests that the process employed to conduct review, that is delegated versus nondelegated, is not a major determinant in a successful review program. Deere & Co., for example, has contracted since 1978 with two review organizations, one employing primarily delegated review and one nondelegated review. After nearly 4 years of review, the Iowa Foundation for Medical Care, using basically delegated review for our 110,000 covered persons, has reduced our inpatient days per 1,000 insured persons by 21.4 percent.

The Mid-State Foundation for Medical Care, conducting primarily nondelegated review for approximately 40,000 Deere-insured persons, has reduced inpatient days per 1,000 insureds by 24.8 percent. The difference between delegated and nondelegated is negligible over time when the purchaser, in our case the employer, closely scrutinizes and monitors the review program. You simply cannot sign a contract and wait inactively for an annual report and expect results.

We would thus urge the subcommittee to allow flexibility in the review process, but to exact specific outcome measures for reductions in inappropriate inpatient days as a basis for the performance contract.

In a similar vein, we would urge the subcommittee to provide exceptions with respect to the size, that is, number of admissions reviewed, or review organizations in a single State. While the Mid-State Foundation for Medical Care reviews only 46,000 Federal admissions and 24,000 private admissions, they have been very successful, as I have noted.

One final major experience we have realized that has implications for the content and direction of this bill relates to the imperative for review conducted by physician-based review organizations, as opposed to programs conducted by insurers, intermediaries or inhouse by employers. Review cannot successfully be accomplished purely on a quantitative statistical basis. Although quantitative data is essential in review programs, qualitative input relative to policy, procedures, and review, must be conducted by physicians if we are to help assure quality of care while reducing inappropriate services and associated costs. The cost of health care must be addressed, however quality of services must not be inappropriately compromised.

MBGH remains committed to private review programs as one of many tools to help reduce the cost of health care services and to create an important type of dialog with providers in a unique forum. It is not a panacea—expectations should be realistic. Our organization, its members, and staff have a continuation of knowledge and experience that can be tapped as part of the bill's technical modifications. We would be pleased to participate in this process at the subcommittee's request.

Thank you very much for this opportunity.

[The prepared statement of Duane H. Heintz follows:]

Testimony
S 2142
Peer Review Improvement Act of 1982
Senate Committee on Finance
Subcommittee on Health
1 April 1982

By:

Duane H. Heintz
Manager, Health Care Services
Deere & Company

Chairman, Board of Directors
Midwest Business Group on Health

Mr. Chairman, members of the subcommittee, and distinguished guests, I am Duane Heintz, Manager of Health Care Services for Deere & Company and Chairman of the Board of Directors of the Midwest Business Group on Health. I would like to thank you for extending this invitation to comment on the proposed Senate Bill 2142, the Peer Review Improvement Act of 1982.

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MBGH remains committed to private review programs as one of many tools to help reduce the cost of health care services and to create an important type of dialogue with providers in a unique forum. It is not a panacea--expectations should be realistic. Our organization, its members, and staff have a combination of knowledge and experience that can be tapped as part of the bill's technical modifications. We would be pleased to participate in this process at the subcommittee's request.

Thank you for your time and your interest in this critical issue.

Senator DURENBERGER. We appreciate that offer and the help you have been already and your testimony today.

Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, EXECUTIVE DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, D.C.

Mr. GOLDBECK. I am Willis Goldbeck, the executive director of the Washington Business Group on Health, an organization of some 200 major employers that, pertinent to this hearing, provide the medical care coverage for some 55 million persons in the United States.

Our members are generally characterized as conservative, especially economically, supportive of President Reagan and opposed to Government regulations. However, they are also increasingly aware that governmental policies of cost-shifting are not synonymous with cost-saving. They are increasingly conscious of the necessity of a utilization review system with responsible Federal participation, and have learned from experience that PSRO programs can be very cost-effective.

They have also learned that all Government involvement in medical care is not bad, and that the market certainly has not demonstrated any capacity to serve those who have no money with which to purchase anything in that market.

The principles upon which S. 2142 are based should be supported by every consumer, every major purchaser of medical care and by every provider who has an honest concern for the quality of health care.

I hope your committee will reject the rather confused logic of the administration's position that progress has been made during the time of PSRO's, but not enough progress has yet been made, therefore the way to get more progress is to get rid of the PSRO's.

Let me address some other points of opposition to PSRO's and to S. 2142. The deregulation espoused by those who want to see the PSRO program eliminated will not help the economy. It will only create a void that will fast be filled by excessive and otherwise unnecessary hospitalization. This is financial and human waste our members are not prepared to accept. Quality physicians will not lose freedom and patients will not lose freedom; the only loss will be unnecessary care.

Some say utilization review is fine but the Federal Government should not participate. Such an abdication of responsibility would not benefit the taxpayer. More importantly, it is a direct attack on the medicare beneficiary. The message is clear: PSRO works and is to be encouraged for the private insured patient, but there is no need for the Government to apply the same rigor of utilization review and financial accountability for patients whose care is publicly financed. It simply does not make moral or economic sense.

We are extremely concerned about the idea that private sector cost management and business coalitions can be construed as a replacement for what the Government no longer wants to do for those for whom it has the financial and service responsibility. We are making tremendous progress in the private sector. It is not enough. It is not a panacea. It is indeed only a beginning, and should not be saddled with responsibility that it cannot achieve, has not sought and for which it has no authority.

I would also note that delegated review has been determined by most of our members not to be a successful system. In the bill there is also the possibility of a hospital association or some other hospital-dominated organization becoming the review group. I think you might want to exclude that in the same vein as delegated review itself is excluded. We, too are concerned about the bill's support for insurance carriers as review agencies and feel that you will hear that the most responsible carriers will also be in opposition.

The contention that the current PSRO program has failed is false. Ironically, it should also lead to even greater support for S. 2142, since your bill improves the current system while retaining only those features which have been very successful. The 147 existing PSRO's are those that passed the HCFA test of quality and economic efficiency. If HCFA is no longer satisfied with that, then the blame must be placed on the HCFA criteria that those PSRO's passed, or upon the HCFA management of the program in which those PSRO's functioned.

Finally, we reject the contention that PSRO is antihigh quality medicine. We support PSRO precisely because it is a vehicle for the finest physicians to work together for a more efficient and accountable delivery system.

In closing, let me reiterate that our support comes from profit-oriented private business leaders who believe S. 2142 can improve quality of care, reduce waste, and make progress in bringing needed accountability in the struggle to reduce the escalation of medical care costs. S. 2142 is a model of what Congress is supposed to do—learn from both public and private experience, attain balance between regulation and market forces, and exercise leadership that is supportive of our basic health care objective, which I hope we continue to agree is access for all to needed care at a price that can ultimately be afforded.

On a final note, do not let the current PSRO program be eliminated until an adequate replacement, hopefully based upon S. 2142, is accepted. Thank you very much.

[The prepared testimony of Mr. Goldbeck follows:]

A New Approach to PSRO

Testimony on S2142
The Peer Review Improvement Act

by

Washington Business Group on Health

Willis B. Goldbeck
Executive Director

April 1, 1982

My name is Willis B. Goldbeck, Executive Director of the Washington Business Group on Health.

Background

The first paper produced by our Group, back in March 1975, was a Statement of Principles which called for, among other things, "peer and utilization review".

Since then, we have worked to increase employer involvement with UR systems generally and PSROs specifically. Local business groups which we have assisted, such as the Midwest Business Group on Health, have established active programs to further private sector UR programs.

These efforts, combined with those of other business organizations and individual corporations, have provided hard evidence that UR/PSRO programs can produce a sound return-on-investment for the purchasers of hospital and medical care services.

In testimony before this committee and the Ways & Means Health Subcommittee, we have presented the specific results of these employer programs. In addition to those of us who come from business groups, individuals representing such firms as Caterpillar, Deere, and Motorola have spoken on behalf of PSRO declaring the value their companies received.*

Currently, in our work with individual employers and the local business groups, the subject of data systems for utilization management is the number one topic. Employers are becoming increasingly sophisticated about health care economics and delivery systems. They have learned that most of their cost management efforts will yield a low return unless built upon a solid foundation of reliable data. In turn, that data needs careful review by local physicians so it can be used to positively influence physicians' patterns of practice. The PSRO system as proposed in S.2142 meets both these criteria.

Key Features of S.2142

S.2142 is a responsible reflection of today's real needs. In brief, we specifically support:

1. ***The continued commitment to UR in Medicare.***
   Just at the time the PSRO/UR systems are demonstrating increased effectiveness, and at the time we are all seeking any progress in the cost control battle, it would be totally contradictory to have the nation's largest single payer abandon any review of the appropriateness of care delivered to Medicare patients.

**The Appendix contains examples*

2. ***The change to a competitive contract based system***
   Precisely because UR/PSRO has proven to be cost effective, it is now appropriate to place this successful system on a more market forces economic basis. This change is also consistent with the general movement toward a more competitive system.

3. ***Increased participation by the private sector***
   We appreciate your recognition of the private sector experience and of the need to have a system in which all payers participate. The acceptance of non-PSRO and for-profit UR groups is also a welcome change. If such groups can provide quality services with greater cost efficiences, it would be contrary to our national economic goals to forbid their participation.

   The possibility of insurance carriers obtaining review contracts causes considerable concern. This would give the paraticipating carrier a major competitive advantage. Further, you would have to establish provisions requiring that review data collected by one carrier be made available to all carriers and other payers. Given these difficulties, it may be preferable to simply not allow the carriers to be designated as review contractors.

4. ***Elimination of delegated review***
   This is actually a progressive stop which should be applauded by all who desire UR/PSRO to place quality of patient care at the top of their priorities. Only an independent review group can be expected to operate free from the biases and economic pressures that naturally face any group that had to review itself.

5. ***Requiring Medicare to make patient data available***
   It is essential that everyone understand the multiple values of UR/PSRO and that personal confidentiality is not an issue. The large purchaser does not need to know the identity of any patient. Not only would this information be a violation of confidentiality, it would also be useless. The purchasers do need to have data upon which accurate quality of care and price of service comparisons and analysis can be made.

   This same information should be publicly available to assist the consumer in the wise utilization of their local medical care resources. If we are not prepared to have a truly informed purchasing public, then we are also not prepared to move toward a consumer choice, market forces health care delivery system.

The Current PSRO System

Recognizing the incredibly full Congressional schedule this year, creative new proposals like S.2142 may not be given the opportunity for passage. If this problem does arise, we urge Congress not to eliminate funding of the current PSRO program. The positive results achieved by private employers, as a result of their contracts with PSROs, could also be achieved by the Federal government, if it wished to do so.

Last year, the Administration made a commendable effort to eliminate those PSROs considered to be less effective. Congress provided funding for the continuation of only those PSROs that the Administration claimed its own analysis had proven to be cost effective. Therefore, if Congress were to accept the current budget proposal, you would be eliminating these physician organizations in which you made an investment last year based upon that determination of effectiveness.

Last year, the Administration's justification for ending the PSRO program was that it would no longer be needed due to the Administration's competition program. To date, the Administration has not sent a proposal to Congress so we are several years away from achieving system's alterations that might someday justify an end to the PSRO program. Consequently, there is no valid basis for terminating Peer & UR under the Medicare progams.

We reaffirm our commitment to the requirement for utilization review in Medicare and for the PSRO program. We urge you to reject the proposed elimination of the program and the void it would create; a void which would surely be filled with even more unnecessary and expensive hospitalization.

Additional benefits of S.2142

From the perspective of the purchaser of hospital and medical care services, the system established by S.2142 has several other advantages.

1. *The focus is first on quality, then on cost. This establishes a very important principle: the preservation of quality care in the appropriate setting is consistent with the economic goal of the most cost-effective system.*

2. *Providing accountability for the choice between inpatient hospitalization or the use of outpatient facilities.*

3. *Recognizing that the review should encompass both inpatient and outpatient care. This is particularly appropriate in light of the significant amount of Corporate reorganization now underway within the hospital industry and the emergence of multi-hospital institutions, many of which will combine varied systems of health care delivery.*

4. *The review process respects unique local conditions and retains the involvement of dedicated local physicians reviewing the appropriatenss of care.*

5. *Protecting patient records from subpoena or disclosure is an essential ingredient ensuring confidentiality and encouraging physician cooperation.*

Conclusion

No doubt, some will oppose this bill on the grounds that it retains Federal involvement with the practice of medicine and because it grants authority to the Secretary of DHHS.

As employers strongly supportive of the Administrations' attempts to reduce undue governmental regulations, we have carefully weighed this issue.

After careful consideration, we support S.2142 as a very rational effort to strike a responsible balance between the goals of health care cost control and governmental deregulation. This bill does contribute to deregulation and moves toward a more competitive system. S.2142 takes the bold step of placing a federal program on a performance contract competitive basis that is designed to serve both the public and private purchasers of health care services. And, finally, as tax payers, we accept the basic commitment inherent in the philosophy of S.2142 that the federal government has an obligation to participate in the sound management of the health care services it uses our tax dollars to purchase.

APPENDIX TO TESTIMONY ON S.2142

The Peer Review Improvement Act

Examples of Private Sector Programs

__Minneapolis:__ 16 employers join with the PSRO/Foundation for an experimental, community-wide utilization review program. Participants include Honeywell, 3M, General Mills, Control Data, and Pillsbury. This is a non-delegated review program that includes preadmission review and covers some 138,000 lives. In one year, this group has seen its days per 1,000 lives drop and its average length of stay fall to 5 days...which compares very favorably with an average of 7.6 days for the similar Twin Cities population which is covered by Blue Cross/Blue Shield but does not participate in the review program.

__Phoenix:__ Motorola, Arizona's largest employer, has worked with the Maricopa Foundation on the development of its Certified Hospital Admission Program (CHAP). Their results show that not only can significant savings be quickly achieved but also that progress can be sustained over several years. While average length of stay is over 7 days nationally, it has dropped to 5.5 days for Maricopa reviewed patients. Days per 1,000 are also some 1/3 less than the non-reviewed Arizona Blue Cross/Blue Shield patients.

__Caterpillar:__ According to Ron Hurst of Caterpillar, their PSRO contract resulted in reductions of:

• *Admission rates*	*10%*
• *days per 1,000*	*19.2%*
• *Length of Stay*	*10.3%*

During the period 1974-77 Caterpillar's direct health care payments increased at a rate of 21% compounded annually. The PSRO contract began in 1978. In 1979, while the rest of country was experiencing even greater cost increases, the increase at Caterpillar fell to 11.8%.

__Deere & Company:__ A national leader in cost management, Deere's experience with PSRO in Illinois and Iowa provides two striking examples that should be encouraging to any purchaser of medical and health care services:

CATEGORY	REDUCTIONS ACHIEVED	
	ILL	IOWA
Days per 1,000	*30.2%*	*18.7%*
Length of Stay	*1 day*	*.5 day*
Admissions per 1,000	*17.3%*	*10.6%*

These examples are also relevant to the design of S.2142 since the Iowa case was a delegated review program and produced savings which, while certainly welcome, were significantly less than the non-delegated program in Illinois.

__Sundstrand:__ During the 2 1/2 year period of their PSRO contract, their length of stay was reduced to below the average of the area (Illinois) as well as the nation:

Nation	*7.1 days*
Area	*6.4 days*
Sundstrand	*5.9 days*

__Goodyear:__ A one-day reduction in average length of stay resulted in a savings of $30,000 on a basis of only 600 admissions for Goodyear's Springfield, Illinois workers.

Senator **Durenberger**. Thank you very much.
Mr. O'Brien.

STATEMENT OF G. ROBERT O'BRIEN, SENIOR VICE PRESIDENT, CONNECTICUT GENERAL LIFE INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. **O'Brien**. Thank you, Mr. Chairman. I am G. Robert O'Brien, a senior vice president at Connecticut General Life Insurance Co. Today I am testifying on behalf of the Health Insurance Association of America, which is comprised of 309 companies and accounts for the writing of 85 percent of the commercial health insurance in the United States today.

Mr. Chairman, I have submitted written testimony. Rather than reading that, I would like to just make some overview comments.

Senator **Durenberger**. Everyone's written testimony will be made part of the record.

[The prepared testimony of Mr. O'Brien follows:]

STATEMENT OF THE
HEALTH INSURANCE ASSOCIATION OF AMERICA
ON
S. 2142 "PEER REVIEW IMPROVEMENT ACT OF 1982"

PRESENTED BY

G. ROBERT O'BRIEN

Good morning. My name is G. Robert O'Brien, Senior Vice President of Connecticut General Life Insurance Company. I am testifying today on behalf of the Health Insurance Association of America which consists of 309 insurance companies that are responsible for about 85% of the health insurance written by commercial insurance companies in the United States today.

Mr. Chairman, we wholeheartedly support the continuation of utilization review programs throughout the nation. We believe that S.2142 contains the essential ingredients for an effective public-private partnership that will sponsor and sustain local utilization review programs.

All of us here today are concerned about and frustrated by the explosion of health care costs. The health cost inflation problem is so complex that a ready solution will not be found in any one piece of legislation or in any one program. We are more likely to see incremental progress being effected by the concerted cost containment actions of all the participants in the health care system. Determining the appropriateness of hospital admission and length of stay through utilization review is one of the cost-effective programs that the public and private sectors can co-sponsor.

Utilization review is most effective if all patients, regardless of payment source, are subject to review. One of the reasons the current PSRO program is not more effective is that it does not contain enough incentives to stimulate widespread private sector involvement.

Private insurance companies support utilization review

The insurance industry's involvement in utilization review pre-dates the Federal PSRO program. For example, in 1971 Connecticut General worked with Aetna Life & Casualty, Travelers, Connecticut Blue Cross, Health Insurance Association of America, the Hartford County Medical Society, and the nine area hospitals to establish the Hartford County Health Care Plan's private sector utilization review program, one of the nation's earliest. This program was not fully implemented, however, until after the publicly funded PSRO became operative.

Since 1978 the Hartford County PSRO and the Hartford County Health Care Plan have worked closely with the nine area hospitals to review selected patients from all payment sources. The program saves almost $3 in hospital costs for each dollar it spends. The Hartford County PSRO and Hartford County Health Care Plan have successfully performed other cost containment activities as well. They identify for hospitals the inpatient surgical procedures that could have been done on an outpatient basis, and they are pilot testing a program that would review the appropriateness of ancillary services. Much of their success in changing provider behavior can be attributed to their sponsorship and endorsement by the local physician community, and the hospitals.

Commercial insurers have successfully contracted in several other areas with local PSROs and Foundations for Medical Care to perform concurrent utilization review of their insureds. At Connecticut General, utilization review is one of the components of our cost containment program called REMEDI. Most components of the program - second opinion surgery, contract and benefit plan design, and employee education - are offered nationwide. Our utilization review activities, however, are restricted to those areas where local PSROs have been able to successfully negotiate with hospitals to review our insureds. In these areas we have reduced hospital stays by 1/3 - 1/2 day and have saved about $3.50 for every $1.00 spent in the review process.

Hospital participation in review is essential

It has been possible for commercial insurers to contract with the PSROs only when the local hospitals have been willing to participate in the program and to give the PSROs access to the records of privately insured patients. In general, successful private sector review programs exist only where there is a supportive medical community or the backing of major employers who encouraged area hospitals to cooperate with local PSROs. It is easier, of course, for an insurer to reach an agreement with PSROs that have successfully negotiated with the area hospitals to review privately insured patients. Thus, after one insurer begins to review its patients in an area, other insurers quickly follow.

We have found, however, that many hospitals are unwilling to allow review of private patients. This reluctance of hospitals to participate in the private utilization review process has been a major impediment in our attempts to expand our utilization review activities. In order to promote private sector participation in utilization review it is essential to require hospitals to cooperate with private sector utilization review efforts. We therefore commend, Mr. Chairman, the intent of S.2142 to allow the Federally designated review organization equal access to relevant medical information of public and private patients. As worded, however, Section 4 only requires the hospitals to provide data. We believe that the hospital should be required to provide the actual medical record. Otherwise, the hospital might claim that it had satisfied the bill's requirements by merely providing summary data which would be insufficient to conduct concurrent utilization review. The actual patient record must be reviewed daily in order to assess the appropriateness of the patient's stay. We therefore submit for your consideration the following wording change: Section 4(3)(E) should read "to release medical records . . ." rather than "to release data . . ."

S.2142 improves utilization review in several other ways

This bill also contains several other ingredients essential to the development of a successful public-private sponsorship of utilization review activities. One is the consolidation of geographic areas. Under the current law, in order to review our insureds in a large metropolitan area, for example, insurers must negotiate with several PSROs. This introduces an undesirable element of complexity and uncertainty in that the same insured may be subject to review during one episode of illness and be exempt during another episode of illness at another institution.

Another important change this bill proposes is the elimination of delegated review. The review process can be objective only if a review organization, not a hospital, makes the final determinations on quality and necessity of care.

Third, in shifting the role of the Federal government from sponsor to contracting agent you have recognized the value of competition in the health care marketplace. Review organizations would be encouraged to compete for Federal and private sector business. Your bill goes a long way toward transforming the current PSRO program from one which is primarily Federally sponsored and over-regulated to one which will reflect the efficiencies of the private marketplace.

Definition of review organization presents conflict of interest problems

We believe that unless this legislation insures that only disinterested entities are eligible for the Federal contract, you will seriously compromise the goals of S.2142. One of the goals of S.2142 is to restructure and streamline utilization review activities so that they are more efficient and effective. The other major goal is to stimulate private sector entities to review their patients. These goals could be undermined if the review organization were to have a potential conflict of interest. We strongly suggest, then, that neither hospitals nor insurers be eligible for the Federal contract.

We do not believe, Mr. Chairman, that a review organization controlled by hospitals would be objective. To allow them to review themselves would seriously compromise the effectiveness of the review process. You yourself have recognized this in S.2142 by no longer allowing the review organization to delegate review authority to individual hospitals.

Allowing an insurer to contract with the Federal government to perform utilization review activities will hinder participation in the program by other insurers. The insurance market is intensely competitive. Even the appearance of conflict of interest would be enough to dissuade many insurers from signing a contract with a competitor. In addition, insurers would be dissuaded by potential abuses of the review organization, and by the marketing disadvantage inherent in contracting with a competitor for one of their products.

Mr. Chairman, this would be a problem particularly in areas where hospitals were willing to release medical records only to the agency the Federal government had contracted with. As a practical matter, in these areas the private sector would have to contract with that same entity. In many cases, insurers would decline to have their patients reviewed by a competitor resulting in an overall lower level of private sector participation in and support for utilization review activities.

With your permission, Mr. Chairman, I would like to submit, for the record, a proposed amendment to S.2142 that would prohibit hospitals, insurers and third party administrators from becoming the Federally designated Utilization and Quality Control Peer Review Organization.

1152(c) For purposes of this section and Sec. 1153 (b)(2) no utilization and quality control peer review organization shall itself be or be affiliated with 1) any entity which directly or indirectly pays medical expense benefits to facilities under review or 2) any such facility or association of facilities within the local or regional area to be served by the utilization and quality control peer review organization.

Conclusion

In closing, we think that S.2142 is an important piece of legislation. Our experience has shown us that concurrent utilization review lowers costs by lowering utilization, without sacrificing quality. By removing barriers to private sector involvement, this bill fosters review of all patients, which is an important first step toward systemwide cost containment. If amended as recommended, S.2142 could enhance the cost-saving potential of utilization review by streamlining and strengthening the current program, and by allowing the private sector to expand their activities into areas that are now impenetrable.

Mr. O'Brien. First of all, I would like to say that we enthusiastically support Senate bill 2142. We have found through our experience over the last decade that peer review organizations and hospital utilization review have been very effective means of controlling costs. We do feel that utilization review should apply to all patients; that is, both private and public sector patients. We feel also that this bill is an excellent example of a workable partnership between the public sector and the private sector.

At Connecticut General, we have been working with peer review organizations since 1971. This started in the Hartford County area in Connecticut, and we have expanded to other areas across the country. We have found that as a minimum, utilization review saves $3 in hospital costs for every $1 spent. And in some areas it has gone as high as $7 of savings for every $1 spent.

We now find that we are actively marketing this as a part of our cost containment program to all of our customers. The coined name for the cost containment program is REMEDI. A key part of REMEDI is the utilization of PSRO's that are in existence throughout the country.

Unfortunately, utilization review only works in the private sector when the hospital is willing to participate. Unfortunately today, many, many hospitals do not want to participate in private sector hospital utilization review programs. We do feel, however, that the bill will help substantially to encourage these hospitals to actively participate.

As a suggestion, on page 28 the bill talks about the release of data. We submitted in our written testimony a couple of minor changes. One of them is that we feel that the words "release of medical records" should be substituted for "data," otherwise, the hospital could release summary data which would be inadequate for the PSRO to work with.

We feel that Senate bill 2142 improves the hospital utilization review process. It consolidates geographical areas. It eliminates delegated review. I think it will reduce regulation and allow the free market to operate.

I do think, however, that one of the major objectives of this bill will be compromised if either hospitals or insurers are allowed to act as the review organization. With respect to hospitals, I think it would be very difficult for them to change their own behavior and reduce their costs. On the one hand, if insurers act as the review organization, it would basically involve using a competitor. I believe that most insurance companies, including Connecticut General, would not find it possible to operate that way in a very competitive marketplace. So what would happen is that the private sector, if an insurer were acting in this review capacity, would not participate to as great an extent as possible in the program.

The end result is that the review organization would have less private funds flowing into it than if someone other than a hospital or an insurance carrier acted in that review capacity.

The conclusion that I have is that this bill is a major step in the right direction toward cost containment. We are very supportive with a couple of minor changes which we have suggested in our written testimony. Thank you.

Senator Durenberger. Thank you, Mr. O'Brien.

What do you think on that latter point about hospitals or insurers being the contractors? What do you think of my so-called threat theory that I articulated at the end of the last panel? That is, that one way to get physicians more involved in the peer review process is to leave the option to contract with insurers or hospitals. Is there enough of a threat there? I really hate to start dictating whether you can be for profit or not for profit and all these sorts of things. I would rather leave it as open ended as possible.

Is there any reality to the threat that leaving it open that way will cause physicians to be more involved in peer review?

Mr. O'BRIEN. I would take a more practical approach. If it were written in the bill that the hospital had to make available medical records on both public and private patients, the physicians would participate. And I do think that we would find that many of the physicians would structure these review organizations across the country. I think you would find some pockets of resistance, but if it is written in the law that the medical records have to be made available, I think it would be effective.

Senator DURENBERGER. Would either of the other of you like to comment on that?

Mr. HEINTZ. I would suspect the concern that we have, that it may be a perceived threat and it may stimulate greater physician involvement, but our experience would indicate that physicians will become involved if they are given the proper incentive or disincentive, as you commented earlier. If review of medically necessary services and appropriateness of the setting of services becomes a part of a benefit plan or a reimbursement situation, so that the funding is really tied for the services to both services that are provided by hospitals and by physicians within hospitals and by physicians, that review networks, I think, will spring up, and we really ought not to tie ourselves—in our testimony we did not refer to PSRO one time. The two organizations that we presently have contracts with happen to also be PSRO's, but they are review organizations first and foremost. And if they prove over time to be unsuccessful in helping us deal with the volume part of our equation, we will contract with other physician-based organizations.

I think with a bill like 2142 and physician organizations having an opportunity to contract on a performance basis with the Government for review, we will see more and more of those. There are other alternatives other than just the insurer.

Mr. GOLDBECK. I think that there is a necessity to separate out the issue of making data on all classes of patients available from the issue of what organizations are eligible to do the review. There is nothing wrong with having for-profit groups doing review. As one who also runs a not-for-profit organization, I know that the financing can be structured in such a way that people can live very handily. There is no purity of purpose or performance that can be guaranteed by insisting that it be a not-for-profit group.

The eligibility of insurance carriers and delegated review to the hospital is a question that should be examined based on whether or not you feel that there will be a reduction in the quality of the review product you get. In both cases, I think the answer is yes, although for different reasons.

Senator **Durenberger**. On the issue of the for-profit versus not-for-profit, though, I guess Dr. Weeks suggested to us that we look at this in terms of ideal world versus real world, and he suggested that at least in West Virginia, in his experience, the adverse experiences with fiscal intermediaries as part of this process in which we are all involved might make it difficult for the community in which he operated to accept a for-profit contractor. I guess we are not forcing one or the other in this process.

Do you agree with his position that we ought to stay away from for-profit?

Mr. **Goldbeck**. I do not think you should exclude for-profits. I think communities should either exclude or include for-profits or not-for-profit groups depending on who can get the job done there and which kind of an entity is viewed as acceptable within that community. But you should not write the rules so that one or the other has to be the contrator.

Senator **Durenberger**. Do either of the other of you have an opinion on the for-profit?

Mr. **O'Brien**. I would agree with that.

Mr. **Heintz**. I would, too.

Senator **Durenberger**. While Max is gathering his thoughts, let me ask you one question, Willis.

I think all of you have characterized peer review as cost-effective, so that is clearly one reason why business, as employers, particularly gets involved in the review. What other reasons in your experience are there for businesses to be involved in one way or another in peer review beyond just cost effectiveness? Are there other reasons?

Mr. **Goldbeck**. Yes; I think that the only way a responsible employer can sell cost containment to the employees, and it ought to be the same motivation for Government, is to link it to improvements in quality of care. When a review mechanism identifies someone as being in the hospital inappropriately, it is not only a financial saving; it can be a lifesaving and certainly a life-enhancing discovery. There is no reason why any employer should spend employees' compensation and stockholders' revenues to support the sustenance of a system that is treating people inappropriately—in the wrong settings, for the wrong amounts of time, and so forth.

If you can set up a mechanism by which the peers of that system can provide a responsible critique, a protective arm, if you will, for every dollar that is saved, there will be a greater saving in the quality of care and quality of life.

Senator **Durenberger**. Thank you.

Max?

Senator **Baucus**. Doctors, I was wondering if you want to add to the questions I asked the earlier panel. That is, whether they felt there was about a 10-percent overutilization in hospital care, as stated by the administration. Do you agree with that statement?

Mr. **Goldbeck**. I would be inclined to think from a national standpoint, that is low. It seems that in any private review system, in any system where there is a reasonable degree of cost sharing imposed, where there are ambulatory services made available, where there are well-designed prevention programs, that a very significant reduction in hospital care can be attained.

Look just at the proposed hospice legislation which is being considered by the Congress right now. That alone could remove terminally ill patients, some 100,000 a year in the medicare program alone, from extensive amounts of unnecessary acute care hospitalization. Consider the studies showing the degree to which physician and hospital visits are actually for psychosomatic problems rather than for physical problems—the list goes on and on and on. Ten percent is a low number.

Senator BAUCUS. I can understand your point that hospitals probably cannot be trusted to reduce utilization, but why cannot insurance companies do a better job in reducing overutilization?

Mr. O'BRIEN. Let me try to respond to that. I am not in favor of having insurance companies function in that capacity for several reasons. One is, the health insurance market today is a very competitive environment from an insurance company's standpoint. If one company were allowed to provide this mechanism, they would have access to data of their competitors. Two, they have a conflict of interest because they could do an effective job on their patients, thereby reducing the cost to their clients, and not as effective a job for the other carriers, thereby making their products more expensive in the marketplace.

I just do not think it would work well. What we would find is most of the companies would not participate. Therefore, private sector funds would not be flowing into the review organization, and the cost to the Federal Government would not be reduced.

I think we can get both the private sector and the public sector involved in utilization review. We are more than willing to fund utilization review through a charge for each patient that is reviewed, which in effect reduces the cost to the Federal Government.

Senator BAUCUS. Have you talked with insurance companies? I do not know whether they are interested in this proposal or not. You have raised some very good points.

Mr. O'BRIEN. I am testifying on behalf of 309 that write 85 percent of the health insurance business, so they are very interested and very supportive.

Senator BAUCUS. They are supportive of——

Mr. O'BRIEN. This bill that we are talking about, S. 2142.

Senator BAUCUS. But just so we are clear, are you saying they are excited about the idea of reviewing each other's——

Mr. O'BRIEN. No; I have two exceptions. One is that I do not think hospitals or insurance companies should be the review organization. The other minor change is on the data versus medical records.

Senator BAUCUS. I understand. Do you agree with Dr. Goldbeck, is that correct?

Mr. GOLDBECK. Willis Goldbeck. I am not a doctor.

Senator BAUCUS. I am sorry.

Mr. GOLDBECK. I am not. [Laughter.]

Senator BAUCUS. Do you agree with Mr. Goldbeck, his statement that probably the 10-percent figure is low?

Mr. O'BRIEN. I would think it is. Our experience has been for just one account that we work with, we were able to reduce their hospital expense in a 24-month period by $1.4 million. So I think we are talking about substantial reductions in hospital confinement across the country. I would say that 10 percent is low.

Senator **BAUCUS**. Thank you.

Mr. **HEINTZ**. Senator, if I might, I think a distinction needs really to be made between—and I am not certain whether the 10-percent figure relates to totally unnecessary hospitalization services or whether it relates to services in an appropriate setting. What we found in our review programs is, there is a very real difference. In some cases, lengths of stay are extended justifiably in the physician's and the patient's minds because, for example, they no longer need the acute care in-patient services of a hospital, but there is no other place to go. There is no other coverage for extended care or some other skill level care, or a bed just simply is not available.

The other illustration of that is that unnecessary surgery, we have found in our experience at Deere and Co., that at least based on our data, indicates that we really do not have unnecessary surgery being done with our employees, but rather surgery being done in the wrong place; that is, in the in-patient facility in a hospital bed for 2 or 3 days, when those procedures could be done on an outpatient hospital basis or in a freestanding surgery center.

So to some degree it depends on the 10 percent—there may be 10 percent of unnecessary hospitalizations, period, but it is a much higher figure if you take into account services that are being provided on an in-patient acute care setting that could be more cost effective and more efficient and with as high a degree of quality provided in a different, lower level of setting.

Senator **BAUCUS**. But do the private or public health insurance programs reimburse for those out-patient procedures?

Mr. **O'BRIEN**. Yes; a good contract would.

Senator **DURENBERGER**. Thank you very much.

Our next panel consists of Dr. Charles R. Griffin, president of the South Carolina Medical Foundation in Columbia; Dr. Michael McGarvey, New York Statewide Professional Standards Review Council, Inc., of New York, N.Y.; Dr. John Graham, president, accompanied by Mr. Patrick Byrne, director of Health Services Information, Foundation for Health Care Evaluation, Minneapolis, Minn.

We will start with Dr. Griffin and go in the order you were introduced. Thank you all for being here.

STATEMENT OF DR. CHARLES R. GRIFFIN, PRESIDENT, SOUTH CAROLINA MEDICAL CARE FOUNDATION, COLUMBIA, S.C.

Dr. **GRIFFIN**. Mr. Chairman and members of the committee, I am Dr. Charles Griffin, president of the South Carolina Medical Care Foundation, and I am also in family practice in Pendleton, S.C.

I am pleased to appear before you today representing 85 percent of the licensed practicing physicians in South Carolina who are members of and support PSRO. We in South Carolina believe that our PSRO is fulfilling the expectations that Congress had for the PSRO program when they enacted the law in 1972. The South Carolina Medical Care Foundation applied for and was funded as a PSRO in July of 1974 and currently has full designation status as a

PSRO. In the 1981 PSRO evaluation, we were ranked as the number one PSRO in the Nation.

You have copies of my printed testimony describing the tremendous impact the PSRO had on the health care delivery system and demonstrates to you what a group of physicians can accomplish when they are committed to the program.

The PSRO in South Carolina has placed great emphasis on assuring that high quality medical care is delivered in our State. Quality review studies have been conducted to insure that the care being rendered meets the standards established by PSRO, and we have demonstrated that the medical profession is capable of monitoring the care rendered by physicians effectively.

Therefore, we would ask that in your consideration of Senate bill 2142, you offer a physicians' group such as ours the first opportunity to be the utilization and quality control peer review organization. My experience has been that groups such as hospitals and insurance carriers conducting utilization review have been ineffective.

Another part of S. 2142 pertains to facilitating private review. A number of South Carolina industries have expressed a serious interest in having the foundation review the hospital care of their employees and dependents covered by their corporate health insurance policies, but efforts toward this were foiled so far by lack of cooperation from hospitals.

Industry has a problem that must be addressed, and that is not only are health care costs continuing to rise at a rate far greater than the overall inflation factor due to the development of newer, more expensive diagnostic modalities and therapeutics, but additional costs are being shifted to the private sector as cuts are made in medicare and medicaid programs. PSRO is not the total solution, but it definitely is an important part of an overall cost containment strategy.

In closing, I would like to reemphasize my suggestion that preference be given in the bill to existing physician-controlled review organizations as the methodology has been refined, data systems developed, personnel competency improved, and physicians are comfortable in working within the existing peer review system.

Thank you for this opportunity to appear before the committee and I will be glad to answer questions.

[The prepared testimony of Dr. Griffin follows:]

STATEMENT OF CHARLES R. GRIFFIN, M.D., PRESIDENT, SOUTH CAROLINA MEDICAL CARE FOUNDATION

Mr. Chairman and members of the Committee, my name is Dr. Charles R. Griffin, and I am the President of the South Carolina Medical Care Foundation which is the Professional Standards Review Organization for the State of South Carolina. In addition to my PSRO activities, I am in Family Practice in Pendleton, South Carolina. Accompanying me today is Mr. William Mahon, Executive Director of the South Carolina Medical Care Foundation.

I am pleased to appear before you today representing eighty-five percent (85%) of the licensed practicing physicians in South Carolina who are members of and support the PSRO. We in South Carolina believe that our PSRO is fulfilling the expectations that Congress had for the PSRO program when they enacted the law in 1972. The South Carolina Medical Care Foundation applied for and was funded as a PSRO in July of 1974. In July of 1975 we received designation as a conditional PSRO and in January of 1981 we received full designation status as a PSRO. In the 1981 PSRO evaluation we were ranked as the number one (1) PSRO in the nation.

I would like to share with you some of the impact the PSRO had on the health delivery system in order to demonstrate to you what a group of physicians can accomplish when they are committeed to the program. In 1980 the PSRO was able to demonstrate a reduction in medically unnecessary days of care of twenty-six thousand (26,000) days. If we apply a conservative per diem charge for a hospital day of one hundred and fifty dollars ($150.00) we have a total dollar saving of three million nine hundred thousand dollars ($3,900,000.00). This is almost three million (3,000,000) more than the PSRO's annual budget.

In the area of hospital ancillary services the PSRO set an objective, in 1980, to reduce the use of Intermittent Positive Pressure Breathing (IPPB) by twenty percent (20%). We not only met our objective but exceeded it for a total reduction of thirty-five percent (35%). Translating this to a dollar figure we find that the total savings was two million four hundred and sixteen thousand three hundred and seventy-five dollars ($2,416,375.00). I have attached as exhibits our impact evaluation by objective for both 1979 and 1980 for your information.

The PSRO in South Carolina has placed great emphasis on assuring that high quality medical care is delivered in our State. Quality Review Studies have been conducted to ensure that the care being rendered meets the standards established by the PSRO. Under the direction of the Foundation Board of Directors and with the help of hundreds of physicians who serve on PSRO committees or as Physician Advisors we feel we have demonstrated that the medical profession is capable of monitoring the care rendered by physicians effectively.

Physician commitment has been the keystone of our success in South Carolina and we would ask that in your consideration of Senate Bill 2142 that you offer a physicians group such as ours the first opportunity to be the utilization and quality control peer review organization. Over the years that I have been in practice I have participated in attempts by other groups, such as hospitals and insurance carriers, to conduct utilization review and my experience has been that they are ineffective. On the other hand I have been active in the PSRO which is governed and operated by physicians and I have seen dramatic improvements in the way health care services are utilized as well as improvement in the quality of care.

Another part of S.2142 I would like to address is the section titled "Facilitation of Private Review". A number of South Carolina industries have expressed a serious interest in having the Foundation review the hospital care of their employees and dependents covered by their corporate health insurance policies. Burlington Industries authorized the South Carolina Medical Care Foundation to contact hospitals and inform them of Burlington's desire for review, this was done and only two hospitals responded to the letter and both refused to allow the review to be implemented. Industry has a problem that must be addressed and that is not only are the health care costs rising as a result of inflation but additional costs are being shifted to the private sector as cuts are made in the Medicare and Medicaid program. PSRO review is not the total solution but it very definitely is an important part of an overall cost containment strategy.

From an economic point of view the expansion of PSRO activity to the private sector would result in significant cost reductions to the government. The more review a PSRO does the lower the unit cost becomes. Another part of the bill that would have the same effect would be the redesignation of areas both by increasing the review load and by eliminating the fixed costs that are common to all PSRO's by reducing the number of organizations.

In closing I would like to reemphasize my suggestion that preference be given in the bill to existing review organizations becoming the "utilization and quality control peer review organization". The years of experience that PSRO's have had should not be allowed to go to waste. In the effective PSRO's the review methodology has been refined, data systems have been developed, personnel have reached a high level of competence and most importantly physicians have become comfortable in working within the existing peer review system.

Thank you for allowing me the opportunity of appearing before this committee. I would be pleased to answer any questions you may wish to ask.

1979 - 80 Grant Proposal
Monitoring Objectives

I. Determine medical necessity of admission and continued stay retrospectively on a twenty percent (20%) random sample of patients exempted from review.

CURRENT DATA

Based on a sample of surveys conducted during 1979 and 1980 we can demonstrate a reduction in medically unnecessary days of care.

1979 Average Percent Medically Unnecessary Days = 13%

1980 Average Percent Medically Unnecessary Days - 11%

DAYS SAVED

Based on an estimated titled days of care per annum at 1,300,000

1979	169,000	Medically Unnecessary Days of Care
1980	143,000	Medically Unnecessary Days of Care

A reduction of 26,000 Medically Unnecessary Days of Care in a one (1) year time period.

SPECIFIC INTERVENTION

Hospital is notified of specific cases where avoidable days were found as well as the overall percentage of medicaly unnecessary days of care. Remedial measures taken have resulted in a reduction of these avoidable days and proven the Foundation's hypothesis that physicians whose patients are exempted from review do not lapse into inappropriate practice patterns as a result of their focused status.

1979 - 80 Grant
Objective - Data Objective II

To reduce the incidence of Intermittent Positive Pressure Breathing (IPPB) by twenty percent (20%) statewide.

CURRENT DATA

1979 Patients receiving IPPB = 20,936

1980 Patients receiving IPPB = 13,501

DIFFERENCE 7,435 (35%)

IMPACT

Average cost of IPPB 325.00 x 7,435 patients = $2,416,375

SPECIFIC INTERVENTION

PSRO developed specific criteria for use of inhalation therapy and distributed them to all hospitals with notice that IPPB charges would not be approved unless service was ordered by a physician initially and reordered every two (2) days as well as meeting criteria.

1979 - 80 Grant
Objective 5.3 A

Decrease the average length of stay by one (1) day.

CURRENT DATA

		No. of Cases	Average Length of Stay
1978	PHDDS	128,649	8.93
1979	PHDDS	146,549	8.11
1980	PHDDS	138,477	8.15

1979 Medicaid Data Days of Care per 1000 = 1,040

1980 Medicaid Data Days of Care per 1000 = 968.6

DIFFERENCE

Average Length of Stay - .82 Days

Days of Care per 1000 = 71.4

DAYS SAVED

Average Length of Stay - 146,549 x .82 = 120,170

Days of Care per 1000 - 242M x 7.14 = 17,278

SPECIFIC INTERVENTION

The PSRO contracted with Yale University to develop South Carolina specific length of stay norms. These norms were shorter than PAS norms previously used thus review took place earlier. During 1980 we have focused eighty percent (80%) of our admissions and implemented SI/IS criteria but as the 1980 data shows there has been little change in the Average Length of Stay.

Eliminate unnecessary surgery.

CURRENT DATA

	1977	1978	1979
Cholecystectomy	2.6	2.5	2.8
Hemorrhoidectomy	.7	.7	.6
Hysterectomy	1.7	1.6	1.5

The above rates are reflective of an acutal decrease in the number of procedures performed, with fifty-six (56) fewer hemorrhoidectomies performed in 1979 than in 1977 and forty-five (45) fewer hysterectomies.

The necessity of cholecystectomies has been studied in all hospitals with ninety-eight percent (98%) of the surgery meeting nationally established criteria.

SPECIFIC INTERVENTIONS

A statewide audit of hysterectomies was conducted in 1978, with specific follow-up of physicians with procedures of questionable need. As well, one (1) surgeon was notified in 1978 that he was in potential violation of obligations. This physician has recently been mailed a notice of violation, for deficiencies, including performance of hysterectomies without documentation of medical need.

The indications for hemorrhoidectomies were studied on a regional and individual basis in 1978 and 1979.

	1977	1978	1979	1980
CHOLECYSTECTOMY	1,337/524,808 2.6/1000	1,293/519,791 2.5	1275 + 277 1,552 /562,757 2.8	1312 + 303 1515 /
HEMORRHOIDECTOMY	367/ .7/1000	343/ .7/1000	237 + 74 311 / .6/1000	228 + 81 309 /
HERNIAS	1,254/ 2.4	1,390/ 2.7	2,281/ 4.0	2,027/
HYSTERECTOMY	881/ 1.7	840/ 1.6	836/ 1.5	892/

1977 and 1978 Number of discharged from PHDSS

1979 and 1980 From AUTOGRP

Number beneficiaries - from William Mahon's chart.

1980 - 81 Grant Proposal
Section 5.4 Objective I

Reduce inappropriate variations in hospital utilization.

A. Reduce average pre-operative days for elective admissions to two (2) days or less in those hospitals with an average pre-operative stay of more than two (2) days by April 1, 1981.

CURRENT DATA

Average Pre-Operative Length of Stay (Elective Surgery)

1979	Average Pre-Operative Length of Stay	2.07
	Total Patients	29,140
1980	Average Pre-Operative Length of Stay	1.91
	Total Patients	28,982

Difference .16 Days

DAYS SAVED

28,982 x .16 = 4,637.1

SPECIFIC INTERVENTION

PSRO wrote letters to hospitals with excessive pre-operative days asking for justification. Medical Care Evaluation Studies were conducted on selected procedures. Claims rebuttal procedure implemented.

1980 - 81 Grant Proposal
Section 5.4 Objective B

Reduce average length of stay in hospital at skilled level of care from present average of 17.3 days to fourteen (14) days by April 1, 1981.

CURRENT DATA

Average Length of Stay awaiting skilled placement:

1979 Total Average Length of Stay	37.68
Total Patients	1,643
1980 Total Average Length of Stay	35.84
Total Patients	1,510

Difference 1.84 Days
133 Patients

NOTE: Total Average Length of Stay used due to lack of accurate data because of focusing.

DAYS SAVED

1510 x 1.84 = 2778.4

133 x 35.84 = 4766.7

SPECIFIC INTERVENTION

PSRO has implemented Pre-Admission Certification in Long Term Care. Encouraging hospitals to start discharge planning at admission when nursing home placement is anticipated. Also uniform level of care criteria has been implemented in Acute and Long Term Care facilities.

1979 - 80 Grant
Objective 5.3 II C

Analyze the ten (10) diagnoses representing an average length of stay higher than the average length of stay for Region IV to determine reasons for the higher length of stay and develop mechanisms for intervention by January, 1980.

CURRENT DATA

Disease of the gallbladder and bile duct without operation and without secondary diagnosis

1978	PHDDS	NATIONAL	REGION IV	SOUTH CAROLINA
		10.5	10.9	11.5
1979				5.3

TOTAL PATIENTS	202
DIFFERENCE	6.2

DAYS SAVED

202 x 6.2 = 1,252.4

SPECIFIC INTERVENTION

Two (2) physicians were identified as major problems. One (1) responded to educational efforts and has improved drastically. The other did not and a sanction letter was issued.

1979 - 80 Grant
Objective 5.3 II C

Analyze the ten (10) diagnoses representing an average length of stay higher than the average length of stay for Region IV to determine reasons for the higher length of stay and develop mechanisms for intervention by January 1, 1980.

CURRENT DATA

Gastric and Peptic Ulcer without second diagnosis and without operation.

		NATIONAL	REGION IV	SOUTH CAROLINA
1978	PHDDS	5.9	5.8	6.6
1979	PHDDS			6.4

TOTAL PATIENTS 328

DIFFERENCE .2

DAYS SAVED

328 x .2 = 65.6

SPECIFIC INTERVENTION

Medical Care Evaluation Studies were conducted and identified problems corrected through communication.

1979 - 80 Grant
Objective 5.3 II C

Analyze the ten (10) diagnoses representing an average length of stay higher than the average length of stay for Region IV to determine the reason for higher length of stay and develop mechanism for intervention by January 1, 1980.

CURRENT DATA

Acute Myocardial Infarction

		NATIONAL	REGION IV	SOUTH CAROLINA
1978	PHDDS	15.0	13.6	14.6
1979	PHDDS			12.3
1980	PHDDS			12.2

Number of Patients (1979) = 3,108

Difference 2.3 Days

DAYS SAVED

3,108 x 2.3 = 7,148.4

SPECIFIC INTERVENTION

A statewide study of Acute Myocardial Infarction was conducted which showed a high mortality rate in many small hospitals. A medical education program was conducted by the State Medical Association as a part of their annual convention. Restudies have indicated reductions in mortality rates and data shows a decrease in length of stay.

Senator **Durenberger**. Thank you very much, Dr. Griffin.
Dr. McGarvey?

STATEMENT OF DR. MICHAEL McGARVEY, NEW YORK STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCIL, INC., NEW YORK, N.Y.

Dr. **McGarvey**. Mr. Chairman, I very much appreciate the chance to be with you here today and to talk about something good that is happening in New York State that has to do with the PSRO's and their performance.

I am a physician currently on the staff of St. Vincent's Hospital in New York City, but for 4 years prior to this, I functioned as the chief medical officer for the New York State Regulatory Agency. So I have had the dubious privilege of being both regulator and regulated.

First, I would like to make the point that today's modern high technology hospital, unless there is a compelling medical reason to be in it, is a very dangerous place to be. It is also very expensive. Therefore, anything that helps to keep patients out of the hospital unnecessarily has very significant both human and financial benefits.

The PSRO's in New York State have proven their ability to do this. In the 2 years of 1978 and 1979, the PSRO's in New York State denied over 395,000 medicare and medicaid hospital days. This yielded a savings of $34 million above and beyond the PSRO costs.

In 1980 the PSRO's in the State exceeded the State's own $5 million medicare savings projections by about three-quarters of a million dollars, saved the taxpayers $2.66, we estimate, for every medicaid dollar spent on the PSRO's.

The State, which I think you may have some sense can be rather skeptical and difficult, was sufficiently impressed with the performance of the PSRO's that it has in fact entered into performance-based contracts with the remaining 14 PSRO's in the State for medicaid review for 1982 and 1983.

The second point that I would like to make is that I think we have to be exquisitely careful about separating the issues of competition in medicine from those that have to do with regulation versus deregulation. In fact, I would be willing to say that the notion of a free market economy in the health care sector is a myth.

Third, I think from 4 years' impression of the State of New York, I think that medicare and medicaid patients are protected from abuse substantially more than private paying patients. Most of the devastating consequences to patients as a result of inappropriate medical care that we saw were on private paying patients.

Fourth, I would say that I think in New York State the PSRO's command the respect and support of the medical community because they involve the most responsible and competent and professionally respected individuals in the medical community in the State. The PSRO's are as tough as they have to be, and I can cite a number of examples about changing major behavior on the part of hospitals and of individual physicians, saving an enormous amount of money.

Finally, I would just say that I think there are no quick fixes, much as Americans like quick fixes. I think we have all come to understand how enormously complicated this field is. The PSRO's have taken roughly 10 years to come to this point. They have cost the Federal Government literally hundreds of millions of dollars to develop. They are just at this point, not surprisingly, coming to the stage of some maturity. I think to throw them out at this point would be very, very sad, very expensive, and would represent either gross ignorance or gross irresponsibility.

I think that the proposals contained in your bill and Mr. Baucus' all move toward what we would very much applaud. That is the enhancement of the PSRO's process with the next step in maintaining an effective physician-based peer review system in this country.

[The prepared testimony of Dr. McGarvey follows:]

PRESENTATION OF
MICHAEL R. MCGARVEY, M.D.
ON BEHALF OF THE
NEW YORK STATEWIDE PROFESSIONAL STANDARDS
REVIEW COUNCIL, INC.

I am Michael McGarvey, M.D. I am an attending physician at St. Vincent's Hospital in New York City. From 1978 through 1981 I was chief medical officer of the health regulatory agency of the State of New York. In recent months I have become a member of the board of directors of the New York County Health Services Review Organization. This has given me a far different perspective -- much closer and more detailed -- than I had as a state government official. Having switched from regulator to regulated, I am more impressed than ever by the capacity of a mature and effectively staffed PSRO to serve the public interest as a professional review agent.

I am more than ever convinced that we must separate the issues of "competition in medicine" from those of regulation and deregulation. In the health care field it is unreasonable, and frankly, naive, to think the bulk of the general public will ever become sophisticated, informed consumers in the same way they are about automobile tires or shampoo, or even about insurance and banking. If anything, increased competition in the health field puts the patient at greater risk and requires sophisticated and accurate regulatory efforts to protect both patients and payers, or rather, taxpayers. I am convinced that the PSROs remain the best, most accurate, and most sensitive regulatory mechanism available for the protection of those at risk.

And when I speak of those at risk, let me make a point that startles most people when I mention it: private patients in our hospitals are at greater risk of substandard medical care than are Medicare and Medicaid patients. The reason is that hospital personnel are very conscious of the fact that Medicare and Medicaid patients' records are under intense scrutiny by PSRO physicians and nurses. It is only human and to be expected that this scrutiny brings about more conscientious attention to the patients' care.

Not all PSROs function with equal success. The government last year terminated about forty of the country's original PSROs But the more than 100 surviving PSROs have a track record that constitutes the most persuasive reason to keep them and support them adequately. For the rest of my remarks I will confine myself to the New York experience since that is the one I know very well, and also because it exemplifies what can work well by way of health quality and cost monitoring.

First, the financial side, which is impressive. In 1980 Governor Carey projected the PSRO review would save the state over five million dollars that year. The PSROs substantially exceeded the forecast.

That year the PSROs denied over 57,000 unnecessary Medicaid acute care hospital days, and freed those beds for patients who needed them. The PSROs in New York State saved the taxpayer

$2.66 for every Federal Medicaid dollar spent on them.

In the two-year period 1978-1979, PSRO monitoring saved thirty-four million dollars over and above what it cost the government to fund the PSROs. The number of disallowed Medicare patient days was 279,279, as well as 116,017 Medicaid days.

In other words, the state government did not look on the PSROs as a costly necessary evil. They were seen as improving patient care and saving millions of dollars at the same time.

Moving to some of the ways PSROs go about their job protecting patients, let me cite a few random examples taken from the past year's records of local PSROs in different parts of New York State.

- One PSRO became concerned about the number of admissions and the inordinate lengths of stay of patients of about two dozen physicians in its area of jurisdiction. The PSRO developed profiles of each of the physicians and asked the hospitals where the doctors had admitting privileges to scrutinize and challenge all the doctors' admissions. The result was a reduction of 34 percent in admissions and 32 percent in days of hospital care. During the year additional physicians were profiled, with still more reductions in admissions and days of hospital care. The overall outcome was a reduction of more than 19,000 days of care. If you apply a cost of $250 a day for a hospital bed, that review by one PSRO of a limited number of doctors in a small area represented a saving to the taxpayer of more than $4,750,000. This is only one dramatic example among many of the deterrent effect of expert, painstaking peer review on physicians' practices.

- Another PSRO saw that many patients with congestive heart failure and pneumonia were staying in local hospitals a long time. They determined to cut 10 percent off the length of stay for such patients in hospitals above the county norm. By close monitoring of patients and hospital records, the PSRO in one year saved a total of more than 5,000 days, just for patients in those two disease categories. At an average of $250 a day, that came to more than one and a quarter million dollars...all of that in Medicare and Medicaid coverage.

- In another part of the state, a local PSRO reduced the number of common surgical procedures to such an extent that $621,000 was saved in the cost of hospital care.

- The PSROs are as tough as they have to be. In one of several similar instances, the PSRO reprimanded a hospital for poor quality of care and overutilization of services. The result was a sizable shakeup in both the administration and medical staff. People were fired and new and better individuals were installed. More nurses were hired to review daily the care patients were receiving. Some attending physicians had their hospital privileges removed and others were required to have second opinions on surgical procedures and to have preadmission certification on all patients they wanted to have admitted.

I could spend hours giving examples of the close scrutiny the PSROs give, even to individual patients. A PSRO check noted a lab report showing elevated potassium, and that the danger of hyperkalemia had not been recognized by the patient's own physician. Corrective action was taken. In another case, the attending physician was on vacation and the covering doctor, who didn't know the patient, had failed to note an abnormal EKG. The PSRO reviewer spotted it and immediately involved the responsible physician for resolution of the problem.

PSRO follow-through is really remarkable. I know a case of a communications gap in which no single person was really to blame, but the PSRO physician saw the problem. It involved a patient with a wound infection who was placed in isolation but kept there too long. Attending physicians didn't realize the patient was in isolation, and the nurses thought that the attendings thought he needed to be isolated. The PSRO reviewed the case and questioned the need for two months of isolation of the blind and elderly patient, who was becoming depressed. The patient was moved to a six-bed room and immediately improved.

The point is that besides the money arguments in favor of supporting the PSROs, there is compelling medical and humanitarian necessity. The taxpayer needs the PSROs. The patient needs the PSROS.

Regarding New York State I can give you complete assurance that the PSROs have the respect of the physician community. They are endorsed by the State Medical Society. They have the personnel and the expertise to review care and costs effectively. No group is qualified to do it better, or as well. They have helped New York State achieve its goals of improving care and reducing excess use of facilities. They have weeded out poor practitioners, and will continue to do so. Only a physician organization is really qualified, or will ever have the necessary credibility to monitor physicians on a continuing basis.

The PSROs have set up strong channels of communication between the State and themselves by developing statewide standards of care, protocols for effective Medicaid review, and giving the state input from the medical community. Finally, the state's 14 PSROs working through their Statewide Council have achieved statewide consensus and uniformity, an enormous accomplishment in a state as large and diverse as New York.

As more and more people are saying, if the PSROs go, someone will have to reinvent them, or their equivalent.

Thank you.

Senator **Durenberger**. Thank you.
Dr. Graham.

STATEMENT OF DR. JOHN GRAHAM, PRESIDENT, FOUNDATION FOR HEALTH CARE EVALUATION, MINNEAPOLIS, MINN., ACCOMPANIED BY PATRICK BYRNE, DIRECTOR OF HEALTH SERVICES INFORMATION

Dr. **Graham**. Thank you, Mr. Chairman. May I say it is a pleasure to be here, from your home State.

I am Dr. Jack Graham, practicing obstetrician-gynecologist in Minneapolis and president of the Foundation for Health Care. I am accompanied by Mr. Patrick Byrne, director of our Health Systems Information Department. I will not read from my text. I will speak as an overview of that.

Our purpose here is to speak in support of S. 2142. I would like to commend Senators Heinz and Moynihan and especially you, Mr. Chairman, for introducing this bill, and I think I would be remiss if I ignored Senator Baucus' work on S. 1250 last year. We at the foundation, we in Minnesota, find it very supportive to have the support for the PSRO function at the national level.

I would like to point out that our presence here is not to be construed as condemning existing PSRO. PSRO has its accomplishments and they have had their accomplishments in Minneapolis-St. Paul and in Minnesota. Days of care have been reduced and quality has been maintained. We have some information available which we can make available to you demonstrating that fact.

These accomplishments have not gone unnoticed by private industry. Sixteen of our area's largest employers came to the foundation and asked the foundation to establish a peer review mechanism for them. Since that has occurred, we have reduced the days of utilization per thousand enrollees by some 200 days. The employers have not hesitated to express their satisfaction at what we have been able to accomplish. I think there is a message in this for the Federal Government.

Your proposed legislation offers several improvements over the existing law. It establishes a contractual involvement where the Government gets accountability, the review organization maintain autonomy, and there is a readily avoidable contract if the desired results do not occur. There is improvement in the method of reimbursement. It will separate the peer review function from the Government. There is a ubiquitous paranoia out there that PSRO's are nothing more than Government agencies. I think the wording in the legislation clarifies that.

In this case, the review organizations will be judged on a preset performance expectation. This is a fair way to judge progress. The bill offers the opportunity of expanding service areas. This will provide economies of scale and yet local physician involvement can be maintained by the use of regional councils.

There are improvements in the program. The emphasis, if this legislation is enacted, will be on results and not process. It eliminates mandatory delegation. We feel that that is a good thing to do. However, we would argue that if some delegation could be held out as a possible incentive for those doctors or hospitals who do perform well.

Finally, it encourages private review. We would suggest that an additional method for improving the environment for private review would be to exempt companies participating in private review from antitrust concerns.

We find this legislation very much to our taste. We have struck a bargain with private industry to do their review and they are satisfied and we stand ready to provide the same service for the Federal Government. Thank you very much.

[The prepared testimony of Dr. Graham follows:]

TESTIMONY ON THE "PEER REVIEW IMPROVEMENT ACT OF 1982"

by

John Graham, M.D.,
President

Foundation for Health Care Evaluation
Minneapolis, Minnesota
April 1, 1982

Mr. Chairman, members of the committee, staff, honored guests, I am Jack Graham, a practicing obstetrician and gynecologist and president of the Foundation for Health Care Evaluation. I am accompanied today by Mr. Patrick Byrne, Director of Health Services Information, Foundation for Health Care Evaluation.

The Foundation commends Senators Durenberger, Moynihan and Heinz for their sponsorship of S. 2142 and Senator Baucus for his sponsorship of S. 1250. As a physician, I am heartened by the expressed intent of these bills to retain the concept of regional peer review. As president of the Foundation, I see the need for such legislation to further the original purposes of P.L. 92-603.

In introducing this bill, Senator Durenberger emphasized that the reasons for which PSRO was created, inappropriate usage and costly health care services, remain with us today. Appropriately, this is the theme of the Foundation's annual report, "Now more than ever."

Now more than ever, Medicare beneficiaries deserve the assurance that the care they receive meets professional standards of quality.

Now more than ever, the American taxpayer deserves to have meaningful and accountable controls over the expenditure of health care dollars.

Now more than ever, communities are turning to market forces as an alternative to regulation. Competitive peer review can stimulate health care competition.

The Foundation has achieved significant annual declines in Medicare days of care per 1,000 and received high marks in the national PSRO evaluation. Nevertheless, we know that federal support of Medicare review in Minnesota would be eliminated under the administration's sweeping proposal to eliminate all PSROs. Proposed as a pro-competition, cost-saving measure, the administration's rather vague program would have neither effect. Rather, those committed to stimulating health care competition and reducing costs should support S. 2142. We support this bill and companion measures because they are consistent with what has been occurring in our community and many others.

The Foundation was organized in 1971 as a private peer review organization. It joined the national PSRO program three years later. Despite programmatic rigidity and limited funds, the Foundation has had some noteable successes in the PSRO program. Of equal importance is the fact that the PSRO program allowed peer review organizations to develop organizational and methodological expertise and vital support systems such as data. Just as the better PSROs began to achieve proficiency, however, they have been "rewarded" with decreased funding, an uncertain future, and the withdrawal of the support of national organizations representing physicians and hospitals.

The private sector, however, has had the wisdom to cut through this political haze. Private industry values the investment which the federal government has made in peer review. Employers want to assure their employees that they are concerned about quality, as well as, cost. Private peer review offers them this assurance. Companies are concerned about accountability for cost containment. Peer review offers this. In less than a year, 16 firms have enrolled slightly under 150,000 beneficiaries in the Foundation's Private Review Program. Others will join soon including the state of Minnesota for Medicaid. The Foundation is unwilling to release the results of an evaluation, still in progress. However, participating firms have not been reticent in claiming substantial reductions in health care expenditures since private review started. Symbolic of how resources available through peer review organizations can help to stimulate health care competition is the role of the Foundation in health care data. The Foundation is providing certain kinds of data only to purchasers of care to help them better manage health care expenditures. The Foundation offers other information only to providers to help them better market the services they provide. These activities are strongly supported by the physicians in Minnesota. In a recent statewide survey of physicians 70 percent indicated that the Foundation was the best organization to conduct peer review; 75 percent indicated that it was the best organization to gather and analyze data on health care.

The phenomena described above are not unique to Minnesota. There are many competent peer review organizations contracting with private industry to reduce costs without jeopardizing health care quality. Many of these are actively engaged in data analysis and education to stimulate competition in health care. Most enjoy both the endorsement and active participation of the physicians in their area. It is from this base, and not from the administration's vague proposals, that change will occur.

The question is not whether there will be regional peer review. Many communities have resolved that question, affirmatively. The questions are whether the benefits of peer review will continue to apply to Medicare recipients and if so, the form which this should take.

There are compelling reasons to continue peer review of Medicare recipients. First and foremost is the fact that many PSROs have substantially reduced days of hospital care through efforts to date. Second, is the real threat that these gains could be reversed if Medicare review is eliminated while peer review in the private sector continues. As a provider I know that many of my colleagues have a tendency to follow the path of least resistance. If the pressure is "off" for federal patients but "on" for other patients, there is little doubt that Medicare days of care will stabilize or increase. Third, we are vitally concerned with quality, as well as, cost issues. PSROs alone have demonstrated a willingness and capacity to take on this responsibility at a regional level. Finally, without federal support for Medicare review vital national resources such as the Uniform Hospital Discharge Data Set could be diminished in extent or quality. PSROs have directly or indirectly managed this resource which is used extensively by those outside the program.

The PSRO program for Medicare could be continued in its present form. However, the Foundation believes that the Peer Review Improvement Act of 1982 will enhance peer review in two principle respects. The bill establishes peer review organizations as competitive private sector entities. The bill also affords these organizations with increased program flexibility.

There are six improvements which this bill makes in contracting provisions.

The PSRO program, like many federal programs, has been burdened by unnecessary red tape in the form of government memoranda and transmittals. These extend to all areas of internal operation including who should be on the board, how much the CEO should be paid and how results should be reported. The Foundation feels that a simple performance contract, readily voidable if results are not forthcoming, offers the government better accountability and the organization the managerial autonomy it needs. The bill replaces grants with performance contracts.

While PSRO grants vary in size, they do not vary in type. All are essentially cost reimbursement coupled with unit costs for discharges reviewed. This situation does not provide incentives to reduce costs. In fact, reimbursement per discharge creates a disincentive to achieve reductions in admissions, a basic purpose of PSRO. The bill offers the promise of options such as cost plus and capitation payment.

The PSRO program has been hampered by the fact that many have viewed it as a federal program. This has created we-they dichotomies between peers. The entire tone of the Peer Review Improvement Act re-establishes peer review organizations as community-based entities which contract with government without becoming a part of government. This is a subtle but strongly felt point.

In a rush to demonstrate accountability to congress, the PSRO program has found itself in the awkward position of being evaluated with criteria established after the fact. Not only is this unfair, it does not increase future accountability since the rules of the game are constantly changing. In last year's national evaluation, the Foundation was judged on criteria developed after the grant was made, partially on performance in a review area assumed after the grant was made and before data was available to document performance. The Peer Review Improvement Act addresses this problem. Peer review organizations would be judged according to performance on a negotiated contract. Such contracts would establish in advance, anticipated results and terms of payment.

Undoubtedly there is a balance between local physician involvement and the economies of scale which larger areas afford. Both are essential. However, there is reason to believe that larger and statewide peer review organizations have some advantages over organizations serving smaller geographic regions. First, with respect to contracting, they simplify the oversight role of state and federal governments. Second, peer review organizations which serve larger areas recognize the need to involve physicians at the local level. Most have gone out of their way to set up regional councils to ensure active participation. Finally, we have learned that there is a core level of administrative support which is essential. Cuts in Part I expenses (administration) tend to have an equal or greater adverse effect than cuts in direct review expenses. Administrative costs such as relationship building, education, program development and financial management are expensive but highly beneficial. The implication is that these administrative costs should not be reduced but should be spread over a large volume of patients under review. The proposed bill enables peer review organizations to achieve these aims.

Peer review organizations have been granted what amounts to monopoly status in a given area. Again, the goal of assuring physician participation remains valid. It is a little frightening to think that the Peer Review Improvement Act could lead to fiscal intermediaries or even commerical enterprises assuming Medicare review responsibilities. The fact that this spectre is so alarming increases its appeal for the Foundation. We are confident that we would win Medicare contracts on the basis of performance and physician support, not simply because we were there first. Under current Internal Revenue Service rulings, it is likely that peer review organizations will have to pay taxes on private review. So, the possibility of peer review organizations themselves being for-profit cannot be ruled out. We would suggest that congress consider two issues with respect to contractor eligibility. First, is peer review (for government or the private sector) a for-profit or not-for-profit activity? Second, are there ways of substantiating the level of physician support claimed by the peer review organization or any competitor? The bill would benefit if language clarifying the congressional intent was added.

With respect to program, there are four major improvements which we believe this bill makes.

P.L. 92-603 and accompanying regulations contain considerable specificity on the types of cases to be reviewed and the review methods to be used. There may have been reason for such uniformity early in the life of PSRO. That time has passed. When private industry approached the Foundation, they said: "You're the experts, you tell us what kind of program we need." The Foundation has enjoyed the freedom to be creative. As a result, the program offered private industry is quite different from the PSRO program. It is unfair to say that program innovation under PSRO was proscribed. But, it has not been encouraged. The Peer Review Improvement Act eliminates earlier language about review process and services to be reviewed. This should stimulate refinement and change. The emphasis in this bill is on results, not process.

The Peer Review Improvement Act eliminates delegated review. The Foundation's Private Review Program is non-delegated. There are indications that non-delegated review should become the predominant form of peer review. However, there may be certain review goals for which delegation remains the best strategy. Delegated quality assurance activities, for example, have been particularly effective since they are integrated into ongoing medical staff activities. Furthermore, the Foundation views delegation as an incentive for hospitals and physicians. The Foundation suggests that the focus of congressional action should be on making delegation optional rather than on eliminating it entirely. This is consistent with the overall intent of the bill which is to afford program lattitude.

There are no provisions under current law which encourage private review. Far-sighted program personnel in the federal government have tried to assist PSROs. The Peer Review Improvement Act essentially affirms such behaviors. Other provisions of the act would mandate provider disclosure of patient care information on those enrolled in private review. This may be helpful in some parts of the country. Since the Foundation maintains a separate data sytem for private review, it cannot comment on the potential value of this provision. However, the general thrust of these sections of S. 2142, facilitation of private review, is laudable. Two other legislative initiatives which would facilitate private review merit consideration. Private industry is reluctant to make private review "binding for payment" because of the threat of antitrust action. It would be helpful if congress would clarify its intentions with respect to whether or not binding private review constitutes an antitrust violation. Another area of consideration would be the integration of private review into laws requiring employers to offer dual choice in health plans. If private review is available in an area, employers could be encouraged to offer it as a benefit to their employees. The dual choice provision has helped to encourage HMO development. It could have similar effects for private review. As a physician I have always been strongly supportive of efforts which help to ensure that patients are assured a common standard of care regardless of the source of reimbursement. As president of the Foundation, I recognize that a larger volume of review translates into improved cost effectiveness for all participants.

Uncertainties over data confidentiality have always plagued the PSRO program. We are reluctant to confront our peers in the absence of detailed information. We have been reluctant to request such information fearing that we might not be able to protect it. We have learned from others that tight confidentiality and disclosure policies paradoxically lead to greater data availability. For example, metropolitan hospitals through their Council of Community Hospitals have established rigid control over data release. The trust so engendered has lead to substantial data sharing among hospitals. There is a lesson to be learned in this for peer review. That is, eliminate mandatory disclosure and encourage voluntary disclosure. The Peer Review Improvement Act adopts this position and frees peer review organizations from the threat of inappropriate disclosure through the Freedom of Information Act. Our intent is to use this safeguard to vigorously pursue peer review while at the same time encouraging providers to share less sensitive and more informative data with the public and each other as a spur to competition.

In the area of programming, there is an important area which is not addressed by the bill. Peer review could play a more active role in health care reform if the bill provided for demonstration projects on financial incentives. We concur that general technical assistance grants should be eliminated since program development is a cost of doing business and not the responsibility of government. Little is known about the link beteween peer review and financial incentives. Yet, the potential yield from such integration appears to be enormous. In the Foundation's Private Review Program, informal arrangements allow reimbursement to be made for alternative care which benefits the consumer, the employer and the provider. Such arrangements have substituted cab fare to a physical therapist for lengthy hospitalization, and defined procedures which can be safely performed in the doctor's office, for example. In the future we hope to experiment with prospective reimbursment for days certified and perhaps with incentive reimburesment for physicians and hospitals who consistently demonstrate cost efficient and high quality patterns of care. We see such initiatives as the future of peer review. But, it is difficult to foresee how such local, private sector efforts could become institutionalized in the national Medicare program without controlled research in several areas. We feel that the Peer Review

Improvement Act could be strengthened by making limited provision for research and development grants on this topic.

To say that the Peer Review Improvement Act of 1982 "makes a good thing better," oversimplifies. This bill offers a new definition of the way in which peer review organizations do business with the government. The bill clears the way for new program initiatives. In achieving these ends, the bill gives peer review a fresh start. This may be its greatest contribution. Opinions about PSRO are so divisive and rigid that many have stopped listening. The Peer Review-Improvement Act offers a new congressional mandate. This mandate makes clear that while peer review is the preferred approach to controlling the costs and improving the quality of care, physicians cannot be complacent about business as usual. Competition for the role is genuine, accountability is direct, the need for innovation is immediate. Peer review organizations have already struck this bargain with the private sector. The Foundation welcomes similar terms from the federal government.

Thank you.

Mr. Chairman, members of the committee, if there are any questions we would be pleased to entertain them.

Senator **Durenberger**. Thank you very much for your testimony. All of your written statements will be made part of the record. I appreciate very much your being able to abbreviate so succinctly.

Let me start with Dr. Griffin from the number one PSRO in the United States of America. I am just concerned about your observations relative to preference. I guess I assumed that given the performance standards that are suggested in the bill and Jack Graham just pointed out the bill requires us to use people who produce results, not just process, that we seem to like here at the Federal medicare level, why would you have concern that your organization might not be chosen?

Dr. **Griffin**. Well, it has been my understanding that it could open to the best bid. You know, people from the private sector form private review groups. In our State we have a good track record. There is good expertise available. It is functioning quite well, certainly not without some bumps in the road, but if we had to participate in a price-effective competition with someone who does not have a track record, but someone who would open up for profit and certainly to try to cut expenses and spend a little of that money lobbying for their business, I am not sure that that would be the safest way to go at the present time. I think the safest way to go is with the proven record.

Senator **Durenberger**. I think I understand better your concern. I guess as I view the proposal, it is a concern without foundation, but if there is a way that we can eliminate that concern in some appropriate fashion, I imagine it would be well for us to do it. Maybe we should make sure that the medicare administration has some incentives of its own to go with the best rather than something that might look better but not have a proven track record.

Before I leave you, let me ask you what experience you have had with delegated versus nondelegated review in South Carolina.

Dr. **Griffin**. Delegated hospitals, those who have chosen to continue to be delegated, have functioned quite well. The ones that are not delegated for their own reasons, I have no percentage or figures at the present time, but overseeing all of it by sitting as chairman of the board, I have seen no difference.

The ones that were delegated and chose to go nondelegated had reasons, and therefore are equally effective at the present time.

Senator **Durenberger**. Dr. McGarvey, what is your opinion about whether or not the success of the operation in New York would be compromised in any way under a contract system such as the one that is proposed in S. 2142? Any problems at all?

Dr. **McGarvey**. No, I think no. In fact, it really would be quite parallel to what the State is beginning to do under the medicaid arrangements anyway. I think the notion of a performance-based approach makes very good sense and I think that the provisions that you made in the bill for exempting it from some of the burdensome aspects of the usual Federal contracting process are very well taken.

Senator **Durenberger**. Do you see any problem such as Dr. Griffin has suggested in the legislation now if we have a very good peer review organization already at work if this legislation were passed? Are they somehow put at risk in our contracting procedures?

Dr. McGARVEY. I think I share his reservations that if you have a situation in which a for-profit organization is interested in getting it and cuts its bid so that it comes in lower without having any real experience in it, that you might put yourself in a bad situation. I would be the first to say that I think sometimes there is an unjustified and inappropriate self-righteousness on the part of not-for-profit agencies, but I think it is also the case that one might consider some sort of a first refusal option for a nonprofit or existing review organization.

Senator DURENBERGER. Jack, let me ask you. You made some reference, and I know it is in your written testimony, to a physician's survey in Minnesota and I am concerned whether or not you have seen any changes in views held by physicians on the whole issue of Federal involvement, financial involvement in peer review. The AMA has a suggestion for a purely voluntary system, and how do you read Minnesota physicians and where they have come with regard to that?

Dr. GRAHAM. Well, I think the survey showed that Minnesota physicians do support the foundation and its function. I think it showed that they do support some surveillance of the health care system. It is my personal view, and I think this is the view of most Minnesota doctors, that a voluntary system just is not very effective.

Senator DURENBERGER. It has been suggested that those who perform review services for Medicare patients and the contractors who pay our bills should be given some financial incentives. Do you have any suggestions as to the type of incentives that would be appropriate for those groups?

Dr. GRAHAM. Well, I think there are some incentives I could discuss with regard to physicians in hospitals who do a good job, if this is what you are asking me.

Senator DURENBERGER. Yes.

Dr. GRAHAM. I think one thing would be to hold out the possibility of delegated review for those people who do a good job. I think if this could be an anticipated reaction for those who do a good job, that would be a positive incentive.

Within our private review program, we are looking at the possibility of prospective reimbursement. By that I mean if a patient with a given diagnosis has an anticipated length of stay, payment could be made upon the time of admission for that patient. This would appreciably improve the cash flow of the hospital, and hospitals are a cash flow business. We feel this would be a significant incentive for hospitals to perform well.

Senator DURENBERGER. The last question I want to ask you is on this business of our suggesting the form of organization. Particularly you have heard the discussion this morning about for-profit versus not-for-profit organizations. What is your position on that issue?

Dr. GRAHAM. Well, the foundation is not threatened by the possibility of a for-profit operation. Our survey showed that the foundation has strong support within our State. We think we can compete with anybody. I think our private review performance shows that. We have wide acceptability among employers. They feel that we do a good job.

I do think that any review organization must have broad physician support, not physicians brought in from outside, but local physicians. By definition, that is what peer review is.

But we do not feel a threat there. I think it is improper to say competition is good for everybody else, but we do not want it. We feel that we can compete with anybody.

Senator DURENBERGER. Thank you all very much for your testimony. I appreciate your being here today.

The last panel consists of Dr. William H. Hotchkiss, secretary-treasurer, board of trustees, accompanied by Mr. Ross Rubin, director of the Department of Federal Legislation, American Medical Association in Chicago; Dr. Bernard Zamostien, chairman of the Pennsylvania Medical Society, Le Moyne, Pa.; and Msgr. James Fitzpatrick, senior vice president, accompanied by Mr. Lindsay Robinson, vice president of regulatory and professional affairs of the Hospital Association of New York State, Albany, N.Y.

Welcome, gentlemen. We will start with Dr. Hotchkiss.

STATEMENT OF DR. WILLIAM S. HOTCHKISS, SECRETARY-TREASURER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL., ACCOMPANIED BY BRUCE BLEHART, DEPARTMENT OF LEGISLATION

Dr. HOTCHKISS. Mr. Chairman, my name is William S. Hotchkiss. I am a physician in the practice of thoracic surgery in Chesapeake and Norfolk, Va. I am the secretary-treasurer of the board of trustees of the American Medical Association, and accompanying me today is Mr. Bruce Blehart of the association's department of Federal legislation.

The American Medical Association is pleased to have this opportunity to testify before you concerning S. 2142 and S. 1250. In our review of these proposals, we have concluded that they would continue many of the objectionable features of the existing PSRO program. We previously testified before this committee recommending that the PSRO program be terminated. Accordingly, we are opposed to the enactment of either bill.

The program that would be established under S. 2142 remains strikingly similar to the existing PSRO program. This similarity is most apparent in the mandatory nature of both programs. This is underscored by the fact that the Secretary shall enter into contracts with review organizations to conduct review activities of services furnished to medicare beneficiaries.

It is further emphasized by the fact that the bill states the functions that the review organization must perform.

Just as the PSRO program shifted from a quality orientation to a cost orientation, we see nothing in the bill that would likely cause a different result. The mandatory nature of the proposal would give the Secretary significant bargaining power in negotiating contracts with review organizations, and cost could become an overriding factor in negotiating objectives that will again be used in judging an organization's performance. Similarly, S. 1250 would not change the major substantive direction of the PSRO program.

While S. 2142 does authorize the review organization to determine the extent of review that it will conduct, it also gives the Secretary the authority to direct that review. This power in the Secretary is significant in our view because of the fact that the Secretary also has the utlimate authority to terminate at will a contract with a review organization.

The review organization is also authorized under the proposal to conduct prereview of services furnished to medicare beneficiaries. Prereview, by its very nature, would be based on arbitrary standards that cannot take into account the individual factors that go into determining an individual plan of medical care. The exercise of such authority could act as a barrier to access to medical care.

We also object to the broad authority of authorizing review organizations to inspect facilities where services are furnished to medicare beneficiaries. Such review authority is redundant and it would be contrary to current deregulatory efforts to eliminate unnecessary and duplicative inspection activities. This provision would authorize the review organization to inspect physicians' offices. Not only would the review organization be authorized to pass judgment upon the care a physician furnishes in his or her own office; the organization would also be authorized to review records and pass upon the office site. Very clearly, these elements present a potential improper intrusion into the physician's practice.

Mr. Chairman, the responsibility for peer review should rest with physicians and cannot be delegated to others. While we understand that physicians' services would be reviewed by a physician under S. 2142, this review function could actually be performed by an organization that did not have even a single physician as a member. The bill's structure could readily result in a designation of a nonphysician organization, including a medicare fiscal intermediary or carrier, as a review organization. We find such provisions highly objectionable.

Mr. Chairman, we appreciate the fact that in introducing S. 2142 you intended to provide needed improvement in the Government's program to review care provided under the medicare program. However, we believe that the bill so closely parallels the existing PSRO program that it will lead to the same problems endemic to that program.

At this point, Mr. Chairman, we feel that it is appropriate to reiterate a statement expressed 1 year ago before this committee by the AMA.

> The AMA recognizes the responsibility of the profession to work to assure quality care for patients undergoing medical treatment in this country. I want to assure you that in the absence of government direction and interference, the profession will vigorously renew and strengthen private sector peer review activities.

Since making that statement last March, the AMA house of delegates has adopted principles for voluntary medical peer review, and the association is currently developing recommendations for the component medical societies to implement voluntary medical peer review.

In past testimony, the AMA has called for the repeal of the PSRO program. We believe that it would be inappropriate to replace this program with a similar one that is so fraught with similar problems.

In making this statement, we do believe that a system of voluntary medical peer review could act effectively in reviewing, to assure the quality of medical care for all patients, and that this could be accomplished without the substantial Government expense of either the PSRO or the proposed review organization program.

The AMA will continue in the development of voluntary peer review. We believe that a voluntary system of peer review would serve the best interests of both the recipient and the providers of medical care.

I want to say at this point that we have had an excellent working relationship with this committee and with its staff and that we look forward to discussing working with you on voluntary peer review in the future. Thank you.

[The prepared testimony of Dr. Hotchkiss follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Subcommittee on Health
Committee on Finance
United States Senate

RE: S. 1250 -- Professional Standards Review Amendments of 1981
S. 2142 -- The Peer Review Improvement Act of 1982

April 1, 1982

Mr. Chairman and Members of the Committee:

My name is William H. Hotchkiss M.D., and I am a physician in the practice of thoracic surgery in Chesapeake, Virginia. I am a member of the Board of Trustees of the American Medical Association. Accompanying me today is Bruce Blehart of the Association's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to testify before you concerning S. 2142, a bill to amend the Social Security Act and provide for a new system of "utilization and quality control peer review" under the Medicare and Medicaid programs. In addition, this testimony will also relate to S. 1250, a bill that would make changes to the current PSRO program by consolidating PSRO areas and authorizing PSROs to focus their review activites. (A summary of these proposals is attached to this statement as an appendix.)

In our review of the proposals under consideration we have concluded that the proposals would continue many of the objectionable features of the existing Professional Standards Review Organization (PSRO) program. We previously testified before this Committee recommending that the PSRO program be terminated. Accordingly, we are opposed to enactment of either bill.

BACKGROUND

Since the early 1960s, the AMA has recognized the need for professional review activities by medical society review committees and utilization review committees of hospital medical staffs. In 1969, three years before the PSRO program was enacted, the AMA stated that there was "no greater challenge facing the profession today than to secure universal acceptance and application of the review concept as the most meaningful method for creating a public awareness of medicine's efforts to assure high quality of medical services at a reasonable cost." At the time of enactment of PSRO, the AMA expressed concern over that program's potential to create "deleterious effects on the quality, confidentiality and cost of medical care." Nevertheless, once it was law, the Association sought to make the PSRO program a viable one that would work to assure the delivery of quality medical care.

For the first nine years of the PSRO program's existence, the AMA worked to improve the program and to maintain it as a mechanism to improve the quality of medical care. However, there has been a growing disenchantment with the program in the profession and elsewhere, and the AMA's House of Delegates called, in December 1980, for the repeal of federally directed peer review programs. At that meeting, the following policy statement was adopted:

> The current Association policy shall be to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all government directed peer review programs, including PSRO.

In testifying before this Committee one year ago on the PSRO program, the AMA strongly emphasized that this position was not a withdrawal of our support for professional peer review of medical service to ensure quality care. We stated that "what the AMA is rejecting is a federally directed review program where the federal direction is no longer interested in patient care or quality service, but has become devoted to the single-minded purpose of restricting health expenditures."

COMMENTS

Mandatory Nature of S. 2142 and S. 1250

In our view, the program that would be established under S. 2142 remains strikingly similar to the existing PSRO program. This similarity is most apparent in the mandatory nature of both programs. This is underscored by the fact that the Secretary "shall" enter into contracts with Review Organizations to conduct review activities of services furnished to Medicare beneficiaries. It is further emphasized by the fact that Section 1154 of the bill states the functions that the Review Organization "must" perform.

Mr. Chairman, we recognize that the stated purpose of S. 2142 is to promote the delivery of health care services that are effective, efficient, economical and of high quality. This, however, was also the stated purpose of PSRO. Just as the PSRO program shifted from a quality orientation to a cost orientation, we see nothing in the bill that would likely cause a different result. The mandatory nature of the proposal would give the Secretary significant bargaining power in negotiating contracts with Review Organizations, and costs could become an overriding factor in negotiating objectives that will again be used in judging an organization's performance.

While S. 1250 would authorize focused review and consolidate review areas, it would not change the major substantive direction of the PSRO program.

Review Functions Under S. 2142

In negotiating and contracting with a Review Organization, the Secretary's actions will be based on provisions in the bill, including those setting out a series of functions that a Review Organization is empowered to perform. Section 1154(a)(1) states that the Review Organization "shall" review the activities in its review area of physicians and other health care practitioners and providers where services are furnished to Medicare beneficiaries. In addition, the Review Organizations are authorized to (1) conduct pre- and post-review of services, (2) examine the records of any practitioner or provider providing services to Medicare beneficiaries, and (3) inspect the facilities where care is furnished by a practitioner or provider to Medicare beneficiaries. According to the proposal, these last three review elements are to be conducted "to the extent necessary and appropriate to the performance of the contract." Section 1154(a)(4) also authorizes the Review Organization to individually determine the types and kinds of cases it will review under the contract with the government.

Our analysis of these provisions indicates authority for federal direction of the review activities. While the proposal does authorize the Review Organization to determine the extent of review that it will conduct, it also gives the Secretary of HHS the authority to direct that review. Section 1154(a)(8) mandates the Review Organization to perform the duties and functions and assume the responsibilities and comply with other requirements that the Secretary establishes. This power in the Secretary is significant in our view because of the fact that the Secretary also has the ultimate authority to terminate at will a contract with a Review Organization.

The broad authority to review virtually every function where Title XVIII reimbursement is made would embrace the provision of medical care in the physician's office and the records that would thereby be generated. The fact that the Review Organization will be authorized to inspect physicians' offices and review physicians' office records raises the potential that the program could direct medical care and interfere in the physician-patient relationship. The AMA is opposed to this element of S. 2142.

The Review Organization is also authorized under the proposal to conduct pre-review of services furnished to Medicare beneficiaries. A decision to undergo medical treatment is generally made in the context of the physician-patient relationship. Pre-review, by its very nature, would be based on arbitrary standards that cannot take into account the individual factors that go into determining an individual plan of medical care. The exercise of such authority could act as a barrier to acces of medical care.

We also object to the broad authority of authorizing Review Organizations to inspect facilities where services are furnished to Medicare beneficiaries. Such review authority is redundant as facilities providing inpatient services to Medicare beneficiaries are generally obligated to meet Medicare conditions of participation. Such provisions would be contrary to current deregulatory efforts to eliminate unnecessary and duplicative inspection activities.

We are even more concerned over the fact that this provision would authorize the Review Organization to inspect physicians' offices. Such an intrusion would be inappropriate and could drive a wedge in the physician-patient relationship. Not only would the Review Organization be authorized to pass judgment upon the care a physician furnishes in his or her own office, the organization would also be authorized to review office records and pass upon the office site. Very clearly, these elements present a potential improper intrusion into the physicians' practice.

Physician Participation Under S. 2142

Mr. Chairman, the responsibility for peer review should rest with physicians and cannot be delegated to others. Under S. 2142 this review function could actually be performed by an organization that did not have even a single physician as a member. We recognize the proposal does state a preference that the Review Organization will be composed of "a substantial number of the licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the area." However, the Secretary is empowered to enter into a contract with virtually any other organization after making a determination that there is no group within the designated area that meets the above requirement and that is willing to enter into a contract proffered by the Secretary to conduct review activities. Moreover, the Secretary has authority to terminate a contract with a Review Organization at will. The bill's structure could readily result in the designation of a non-physician organization, including a Medicare fiscal intermediary or carrier, as a Review Organization. We find such provisions objectionable.

CONCLUSION

Mr. Chairman, we appreciate the fact that in introducing S. 2142 you intended to provide needed improvements in the government's program to review care provided under the Medicare program. However, we believe that the bill so closely parallels the existing PSRO program that it will lead to the same problems endemic to that program. Just as the PSRO program set out to be a mechanism to assure quality medical care and has instead developed into a program principally geared to cost savings, quality of care could become a secondary consideration for Review Organizations.

At this point, Mr. Chairman, we feel that it is appropriate to reiterate a statement expressed one year ago when Joseph F. Boyle, M.D., Chairman of the AMA's Board of Trustees, testified before this Committee:

> The American Medical Association recognizes the responsibility of the profession to work to assure quality care for patients undergoing medical treatment in this country. I want to assure you that in the absence of government direction and interference, the profession will vigorously renew and strengthen private sector peer review activities. It must be remembered that when PSRO was enacted, it merely capitalized upon then ongoing peer review. We at AMA intend that peer review activities -- of which there are many -- be encouraged to take up the slack in review activities if government programs are terminated.

Mr. Chairman, since making that statement last March, the AMA House of Delegates has adopted principles for voluntary medical peer review and the Association is currently developing recommendations for the component medical societies to implement voluntary medical peer review.

In past testimony, the AMA has called for the repeal of the PSRO program. We believe that it would be inappropriate to replace this program with a similar one that is so fraught with similar problems. In making this statement, we do believe that a system of voluntary medical peer review could act effectively in reviewing to assure the quality of medical care for all patients, and that this could be accomplished without the substantial government expense of either the PSRO or the proposed Review Organization program. The American Medical Association will continue in the development of voluntary peer review. We believe that a voluntary system of peer review would serve the best interests of both the recipient of and the provider of medical care.

Mr. Chairman, we request your support and the support of the Committee in our endeavors to develop voluntary medical peer review.

SUMMARY OF S. 2142 AND S. 1250

Purpose

S. 2142 would repeal the existing PSRO program and replace it with Utilization and Quality Control Peer Review Organizations (Review Organizations). The Secretary would be empowered to contract with these Review Organizations for the purposes of "promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services" for which payment is made under the Medicare program. In addition, state Medicaid agencies would be empowered to contract with Review Organizations for utilization review with the federal share of expenditures being 75%.

Area Designations

Both proposals would empower the Secretary to designate geographic areas that would constitute review areas. In general, there would be a presumption that each state would generally be designated as such a geographic area. In situations where a local or regional area has enough review activity, over 75,000 annual hospital admissions under S. 2142 and over 100,000 annual admissions under S. 1250, the Secretary may establish a specific regional area. For each area designated by the Secretary under S. 2142, the Secretary must enter into a contract with a Review Organization to conduct peer review. In situations where no Review Organization exists in a designated area, the Secretary would be empowered to enter into a contract with "any other organization" that is capable of carrying out review functions.

S. 1250 would create an eleven member advisory group to assist the Secretary in consolidating PSRO areas. Of these eleven members, six of them would be required to be physicians who have demonstrated their effectiveness and efficiency while serving as a member of a PSRO. In situations where the number of PSROs in a state is to be reduced, the existing PSROs within the state will be invited to submit consolidation plans to the Secretary. In designating a statewide PSRO, the selected organization must allow for "local physicians to retain responsibility for reviewing care in their local areas." The section of the PSRO Act pertaining to polling of physicians prior to the creation of a PSRO would be repealed under S. 1250, and the Secretary's termination of a PSRO would not be subject to judicial review.

Organization of Utilization Qualitity Control Peer Review Organizations (S. 2142)

A Review Organization would consist of a "substantial number of the licensed doctors of medicine or osteopathy" in a specific geographic area. In situations where the Review Organization does not have adequate personnel to conduct review functions, it must have available to it the services of a sufficient number of physicians to assure that adequate peer review would take place. Minimally, the Review Organization must perform review functions with respect to in-patient and out-patient hospital care. It also must perform a review of the pattern of quality of care against objective criteria that define acceptable and adequate practice.

Contracts betweeen the Secretary and the Review Organization would be for an initial term of 2 years and renewable on an annual basis. In developing the contract, review objectives would be negotiated and these negotiated objectives would be the measuring gauge of the Review Organization's performance. Both parties would have the right to terminate the contract upon 90 days' notice to the other. Federal payments to a Review Organization would be based on an amount deemed by the Secretary to be necessary and proper to pay for the cost of administrative functions. Review Organizations would also be encouraged to make their services available, on a contract basis, with "private agencies paying for health care" and to state agencies administering Title XIX programs.

In situations where the Secretary decides to terminate a contract with a Review Organization, there must be a showing that the Review Organization has not substantially fulfilled its review requirements. Prior to an action to terminate the contract, the Secretary must provide the organization with an opportunity to present pertinent information regarding its performance. To review such data, the Secretary would create a panel to present a report of findings. After the panel has submitted its report, the Secretary would be empowered to terminate a contract upon 90 days' notice, and the Secretary's decision would not be subject to judicial review.

Functions of UQCPROs and Focused Review

A Review Organization that enters into a contract with the Secretary must review the professional activities of "physicians and other health care practitioners and institutional and noninstitutional providers of health care services" where payment is made under Title XVIII. This review would be to determine whether services or items furnished are or were medically necessary, whether the quality of services furnished meets professionally recognized standards, and whether services furnished could be "effectively provided more economically on an outpatient basis" or in a different type of health care facility.

To review services of a physician or osteopath, the Review Organization must have the review conducted by a physician or osteopath. The Review Organization would be empowered to determine whether payment should be made under Title XVIII for reviewed services. Such a determination would be conclusive, with the Review Organization notifying the practitioner or provider of its disapproval of a claim. An opportunity to discuss a negative determination would be provided.

The Review Organization would be able to conduct focused review by its authority to determine the types and kinds of cases it would review. In making its review, it is to "apply professionally developed norms of care" and base its determinations upon regional patterns of practice. The Review Organization would be empowered to undertake review activities "either before or after, or both before and after, the provision of services." In addition, the organization shall, "to the extent necessary and appropriate" examine the pertinent records of providers or practitioners where a review is taking place, and inspect the facilities where services are provided.

S. 1250 would also mandate that each PSRO focus its review activities on areas where there is likely to be inappropriate utilization.

Information and Records (S. 2142)

In collecting information, the Review Organization would keep and maintain records in a form to be determined by the Secretary. Carriers, other peer review organizations, and other public or private review organizations as deemed appropriate by the Secretary would have access to information to "coordinate activities." Information collected by a Review Organization could also be disclosed to assist the Secretary in identifying and investigating fraud and abuse, and for federal or state health planning activities. For purposes of the Freedom of Information Act, a Review Organization or other peer review organization would be deemed not to be an agency of the U.S. government.

Sanctions

Pursuant to S. 2142, a health care practitioner, hospital, or other health care facility, organization or agency that provides services under Title XVIII must assure that it would provide beneficiaries with economical and medically necessary care that meets professionally recognized standards of health care. In situations where the Review Organization determines that such care was not provided in either a substantial number of cases or there were gross and flagrant violations of the obligation to furnish appropriate care, a recommendation may be forwarded to the Secretary to exclude the practitioner or provider from receiving Medicare reimbursement. The Review Organization's recommendation would become final upon either an action by the Secretary or the end of a 120-day period if the Secretary fails to act. Such a determination would be effective upon "reasonable notice to the public and to the practitioner" or provider. The practitioner or other provider would have a right to judicial review of such a determination.

Payments for claims under Titles XVIII or XIX may be withheld under S. 1250 pending a final determination in situations where a claimant has been notified by a PSRO that "a pattern of inappropriate utilization has occurred in the past, and such claimant has been allowed a reasonable time to correct such inappropriate utilization."

S. 2142 provides both civil and criminal immunity to individuals who provide information to peer review organizations in situations where that information is related to the performance of review functions, and the information furnished is not knowingly false. In addition, providers would be deemed to be immune from civil liability where they acted "in compliance with or reliance upon professionally developed norms of care and treatment" as developed or accepted by a Review Organization.

Senator **Durenberger**. Thank you. Let me just say you are fortunate the chairman of the committee is not here today. [Laughter.]

The second member of the panel is Dr. Zamostien.

STATEMENT OF DR. BERNARD ZAMOSTIEN, CHAIRMAN, PENNSYLVANIA MEDICAL SOCIETY, LE MOYNE, PA., ACCOMPANIED BY STEVEN KEYS, EXECUTIVE DIRECTOR, PENNSYLVANIA MEDICAL CARE FOUNDATION

Dr. **Zamostien**. Thank you very much.

Mr. Chairman, ladies and gentlemen, it is a privilege to speak before you here today on Senate bill 2142, the Peer Review Improvement Act of 1982.

I am Bernard B. Zamostien, a practicing certified family practitioner from Philadelphia. I serve as the president of the Pennsylvania Medical Care Foundation, which is a unit of the Pennsylvania Medical Society. I am also a former member of the Philadelphia board of directors of the PSRO for the past 6 years.

Senator **Durenberger**. And you have been here before, too, isn't that right?

Dr. **Zamostien**. Both the Pennsylvania Medical Society and its medical care foundation have a history of endorsing the concept of physician peer review. In the early 1970's the foundation representatives met with the Senate Finance Committee and its staff to discuss the original PSRO concept, namely the Bennett amendment. Upon its passage, the foundation submitted a successful proposal to the then Department of Health, Education and Welfare to act as the first statewide PSRO support center in the country. And this proposal has subsequently been used as a model for support centers and statewide councils over the entire Nation.

Most recently, the Pennsylvania Medical Care Foundation has been awarded an extended contract with the Pennsylvania Department of Public Welfare for the operation of a professional review network. And under this contract, the foundation performs peer review of physicians providing services to medicaid patients in an ambulatory or an inoffice setting.

This review network features a central program administration and an oversight committee by the physicians from the foundation's board of directors, and local committees reviewing the practice patterns of their peers. And this is an expansion of our previous contract that we had with the Department of Welfare for drug prescription review, about which they were very happy and we showed them that it was both locally acceptable and economically performed.

Since the intent of Senate bill 2142 seems to be the elimination of unnecessary regulations by Government involving the operation of peer review organizations, an approach such as that has been taken by the Pennsylvania Medical Care Foundation and the Pennsylvania Department of Public Welfare seems to have merit. Requirements and reporting are simply stated, and they are allowing our physician review committees to focus their attention on the actual review process, rather than on burdensome compliance regulations.

This straightforward review process is a lesson that was learned from the PSRO program, where many one-time supporters of the program became frustrated when the organizations were stymied by Federal regulations and guidelines, and many were tempted to abandon the program.

While the present bill does indicate your awareness of the burdensome regulatory effects of the PSRO program, I certainly urge efforts to eliminate all unnecessary and counterproductive regulations.

Consistent with our policy of physician peer review is the understanding that this review must be performed by physicians representative of the medical community, and whose decisions should include the quality and the appropriateness of medical care and services delivered. While many groups claim to be able to perform peer review, we must caution that many of these groups do not represent the medical community. Data processing firms and others may claim to perform peer review, but these may do so with very limited physician involvement.

Therefore, when a peer review organization is being considered by the Secretary and the Congress, those organizations truly representing a substantial number of physicians should receive the top priority.

While the bill requires local review, some consideration should be given to statewide administration in those States where the number of medicare discharges necessitate regionalization. Statewide administration with regional or local review committees can provide continuity of care of review procedures and results, and can eliminate administrative overhead created by several regional review organizations.

Any federally mandated review program should recognize those principles of peer review that are important to the medical community; namely, local review, physician responsibility, evaluation of quality, medical necessity, efficiency, and appropriateness. And the educational aspects of peer review should be present in any program. A peer review organization should be given freedom to develop policies and procedures to obtain the desired results. A viable program should allow those providers who have constantly demonstrated positive utilization and quality practices to be rewarded by a lesser level of review. The emphasis should be on results, not on the process.

And I believe that organized medicine in Pennsylvania has demonstrated an interest in the organization and operation of peer review programs. We have a responsibility to review the decision of our peers, and I urge that any peer review legislation that is enacted continue to recognize the importance of physician peer review.

I thank you very much.

[The prepared statement of Bernard B. Zamostien, M.D., follows:]

REMARKS OF BERNARD B. ZAMOSTIEN, M.D.
PRESIDENT, PENNSYLVANIA MEDICAL CARE FOUNDATION
BEFORE THE SENATE FINANCE COMMITTEE ON HEALTH
APRIL 1, 1982

Summary of Key Points:

- History of Foundation Involvement in Peer Review Activities
- Elimination of Unnecessary Regulation of Peer Review Organizations
- Qualifications of a Peer Review Organization
- Statewide Administration of Peer Review, With Local Review Committees
- Recognition of Standard Principles of Peer Review
- Level of Review

REMARKS OF BERNARD B. ZAMOSTIEN, M.D.
BEFORE THE SENATE FINANCE COMMITTEE ON HEALTH
April 1, 1982
Washington, D.C.

Mr. Chairman, Ladies and Gentlemen:

It is a privilege to speak before you here today on Senate Bill 2142, the "Peer Review Improvement Act of 1982."

I am Bernard B. Zamostien, a family practitioner from Philadelphia. I serve as the President of the Pennsylvania Medical Care Foundation, which is a unit of the Pennsylvania Medical Society. I am also a former member of the Philadelphia PSRO Board of Directors.

Both the Pennsylvania Medical Society and its Medical Care Foundation have a history of endorsing the concept of physician peer review. In the early 1970's, Foundation representatives met with the Senate Finance Committee and its staff to discuss the original PSRO concept--the Bennett Amendment. Upon its passage, the Foundation submitted a successful proposal to the then Department of Health, Education and Welfare to act as the first statewide PSRO support center in the country. This proposal was subsequently used as a model for support centers and statewide councils.

Most recently, the Foundation was awarded a contract with the Pennsylvania Department of Public Welfare for the operation of a Professional Review Network. Under this contract, the Foundation performs peer review of physicians providing services to Medicaid patients in an ambulatory or in-office setting. This Review Network features central program administration, oversight by physicians from the Foundation's Board of Directors, and local committees reviewing the practice patterns of their peers. An expansion of our previous contract for drug review activities, the Network continues to demonstrate a high quality of review that is both locally acceptable and economically performed.

Since the intent of Senate Bill 2142 seems to be the elimination of unnecessary government regulation involving the operations of peer review organizations, an approach such as that taken by the Pennsylvania Department of Public Welfare has merit. Requirements and reporting are simply stated and allow our physician review committees to focus their attention on the actual review process, rather than on burdensome compliance requirements. This straight forward review process is a lesson that was learned from the PSRO program. Many one-time supporters of the PSRO program became frustrated when the organizations were stymied by federal regulation and guidelines, and this caused many to abandon the program. While the present bill indicates your awareness of the burdensome regulatory aspects of the PSRO program, I urge special effort to eliminate all unnecessary and counter productive regulation.

Consistent with our policy of endorsing physician peer review is the understanding that this review is performed by physicians representative of the medical community and whose decisions should include the quality and appropriateness of medical services delivered. While many groups claim to be able to perform peer review, I caution you that many of these groups do not represent the medical community. Data processing firms and others may claim to perform peer review but these may do so with limited physician involvement. Therefore, when a peer review organization is being considered by the Secretary, those organizations truly representing a substantial number of physicians should receive the top priority.

While the bill requires local review, some consideration should be given to statewide administration in those states where the number of medicare discharges necessitate regionalization. Statewide administration, with regional or local review committees, can provide continuity of review procedures and results, and can also eliminate the administrative overhead created by several regional review organizations. If this approach is permitted, the medical community in each state would be in a position to determine the boundaries and areas to be covered by local review communities, as was the case with our Pennsylvania Medicaid review program.

Any federally mandated review program should recognize those principles of peer review that are important to the medical community. Elements such as local review; physician responsibility; evaluation of quality; medical necessity; efficiency and appropriateness; and the educational aspects of peer review should be present in any program. A peer review organization should also be given freedom to develop policies and procedures to obtain the desired results. A viable program should allow those providers who have consistently demonstrated positive utilization and quality practices to be rewarded either by a lesser level of review or other methods. The emphasis should be on results and not on the process as is the case with the PSRO program.

I believe that organized medicine in Pennsylvania has demonstrated an interest in the organization and operation of peer review programs. We have a responsibility to review the decisions of our peers and I urge that any peer review legislation that is enacted continue to recognize the importance of physician peer review.

Thank you.

BM

Senator **Durenberger**. I thank you very much.

Monsignor Fitzpatrick, welcome back.

STATEMENT OF MSGR. JAMES FITZPATRICK, SENIOR VICE PRESIDENT, HOSPITAL ASSOCIATION OF NEW YORK STATE, ALBANY, N.Y., ACCOMPANIED BY LINDSAY ROBINSON, VICE PRESIDENT OF REGULATORY AND PROFESSIONAL AFFAIRS

Monsignor **Fitzpatrick**. Thank you, Senator.

I am Msgr. James Fitzpatrick, senior vice president of the Hospital Association of New York State. I will summarize my testimony, Mr. Chairman, in deference to your patience.

Senator **Durenberger**. Thank you. All of the written statements will be made part of the record.

[The prepared testimony of Monsignor Fitzpatrick follows:]

STATEMENT OF
HOSPITAL ASSOCIATION OF NEW YORK STATE

PRESENTED BY

REV. MSGR. JAMES H. FITZPATRICK
SENIOR VICE PRESIDENT

ON

S.1250, PROFESSIONAL STANDARDS REVIEW AMENDMENTS OF 1981
AND
S.2142, PEER REVIEW IMPROVEMENT ACT OF 1982

Mr. Chairman, members of the Committee, I am Reverend Monsignor James H. Fitzpatrick, Senior Vice President of the Hospital Association of New York State (HANYS). I am here today, on behalf of the 350 voluntary and public hospitals and related health care facilities which comprise our Association, to present testimony with regard to S.1250 (the "Professional Standards Review Amendments of 1981") and, S.2142 (the "Peer Review Improvement Act of 1982") - legislation designed to preserve the federal role in peer review of hospital and other health care services.

At the outset, I want to make clear the support of the hospital industry in New York State for the continuation of a federal role in the peer review process. As it has involved practicing physicians at the local level and strived to develop local standards to review both the quality and appropriateness of medical care services, the peer review process has proven to be a valid one. While we will not judge the effectiveness of the program on a nationwide level, and feel that many of the benefits of the program are not economically quantifiable, we feel that New York's program - as well as PSRO programs in other states - has proven successful. We are, therefore, opposed to the elimination of the program and feel that any projected savings which might result from such elimination may well be offset by changed utilization patterns.

While we view the two pieces of legislation pending before this Committee as possibly appropriate vehicles for the preservation of peer review and the Federal Government's continued role, we wish to raise some general concerns. When first established in 1972, the PSRO program was based on two guiding principles: quality assurance; and, utilization control. Controlling inappropriate utilization clearly plays a role in assuring the services rendered program beneficiaries are of good quality. Such controls have also yielded the most directly measurable savings. In the ensuing debate over the validity of the continuation of the program, we have lost sight of the quality assurance aspect of the program and focused almost entirely on the issue of cost benefits. This focus has, however, been short term. It is through the program's involvement of local providers that the long term and most profound benefits can be realized. Through peer review, provider behavior and practice patterns can be changed and this, we suggest, is the key to improving both the quality of care and effecting long term savings. While the Federal Government, as a major payor of health services, has a legitimate interest in controlling the cost of government programs, it also has a legitimate interest - a responsibility - to assure that the quality of care is at least adequate to meet needs and ultimately showing continued improvement.

To expand on this, it is, in our opinion, only through the continued involvement of local providers that utilization review can impact both quality and cost. We understand the administration is giving consideration to contracting with fiscal intermediaries to perform utilization review as an alternative. This is an approach we would urge you to reject. Such an alternative is unlikely to receive the support of providers and, as a result, much of the system's ability to impact upon the quality of care would be lost. Additionally, if the intermediaries were to avoid one of the greatest costs to the PSROs, data collection, they would have to use the billing information from claims forms to conduct review. It is clear from experience that billing information is not adequate to assess the quality or the appropriateness of medical services. The intermediaries would ultimately have to revert to an examination of medical records by physician reviewers and the program costs would rise significantly. Again, we feel the provisions of S.2142 and S.1250 to maintain local provider involvement are essential to satisfying the need to assure that the quality of care meets the patient's needs and can be more cost effective than is currently the case.

The comments which follow highlight the sections of S.2142 and S.1250 in which we feel some amendments are necessary to the development of an alternative peer review system. We trust that these comments will be of assistance to the Committee in your deliberations.

DELEGATED REVIEW

Currently, PSROs are allowed to delegate their utilization review functions to hospital utilization review committees in instances where such committees have proven their ability to undertake such functions. However, if S.2142 were enacted as currently written it would repeal this delegation option. Due to various accreditation standards, State law and other factors, utilization review and quality assurance programs will continue on the institutional level even without PSROs or some similar review agency. Rather than require unnecessary duplication of these activities, we would recommend that where review requirements can be met on an institutional level, delegated review be allowed. Similar to the current program, payment for delegated review would be negotiated between the contracting review agency and the provider based on provider costs.

DESIGNATED AREAS

Both bills provide for a consolidation of review areas - a goal we fully support - through employment of an admissions based formula. To the extent that S.1250 takes into consideration both Medicare and Medicaid admissions, we prefer S.1250. However, since review organizations will be encouraged to perform review for private insurers as well, the potential base of admissions requiring review is much higher than the Medicare and Medicaid admission figures. We recommend that the standard be modified to allow for a population base or a total admissions base determination.

DESIGNATION OF PEER REVIEW ORGANIZATIONS

We would agree with the provisions of S.2142 to allow a variety of private sector organizations to enter into contracts to conduct peer review. We are concerned, however, that organizations currently functioning as Medicare fiscal intermediaries may be open to a conflict of interest if they were also to be responsible for peer review. In either case, physician support of the fiscal intermediaries may be difficult to obtain. We would recommend that the language of this section prohibit the Secretary from contracting with payors of service for review functions. We would further recommend that the Secretary by required to give priority consideration for contracts as peer review organizations to existing nonprofit organizations which have already developed active physician involvement and support.

POST DISCHARGE CARE

As written, S.2142 would allow only two days of payment to a hospital in cases where additional time was needed to arrange for post discharge care. We view this as a totally unrealistic provision. The problem of delays in arranging for post discharge care is a national issue and has grown particularly severe in New York State. Because it is principally a shortage of long term care beds, or other alternatives, that has created the problem and not a situation under the hospital's control, we must strongly object to this provision of the bill. We would recommend it be deleted in recognition of the above and because provisions of the Omnibus Budget Reconciliation Acts of 1980 and 1981 would address the situation by establishing lower rates of reimbursement for patients on alternate care status. To deny payment after two days would financially cripple hospitals in New York State and fail to address the cause of the problem.

SANCTIONS

S.2142 provides that if the Secretary fails to act within 120 days of submission of a recommendation for sanctions against a provider by a peer review organization such provider would be suspended from participation in the Medicare program until the Secretary acts. We would recommend that this section be amended to require that the Secretary act within 120 days of such recommendation being submitted to him.

FOCUSED REVIEW

Both bills provide that review organizations will develop a plan of focused review within their designated areas. To the extent that the provisions of S.2142 make a greater degree of reference to focused review and provide that such review be based upon the standard norms of practice within a given area, we prefer the provisions of S.2142.

MEDICAID REVIEW

S.2142 provides that states which contract with a review organization designated by the Secretary for the functions specified in the bill to review Medicaid claims under a state plan will receive federal reimbursement of 75 percent of their expenditures made to the contracting organization. We believe this section should be strengthened to provide that states will be eligible for federal reimbursement of review costs only if they contract with a review organization designated by the Secretary and only if such methods are standards employed by the review organization for Medicare be applied to Medicaid as well. Our concern here is that hospitals and other providers of service not be subjected to different standards of review for different categories of patients based upon source of payment, as is currently the case in New York State. This only leads to confusion and inefficiency in the system and adds to the administrative burden placed upon providers.

We thank the Committee for affording us the opportunity of presenting testimony on the pending legislation and stand ready to provide whatever other assistance you might request.

Monsignor FITZPATRICK. Thank you.

At the outset I want to make it clear that you have the support of the hospital industry in New York State for the continuation of a Federal role in the peer review process. We are indebted to you, Mr. Chairman, Mr. Baucus and our own Senator Moynihan for your efforts in this behalf.

We are therefore opposed to any elimination of the program and feel that any projected savings that might result from such elimination may well be offset by changes in utilization patterns.

The PSRO program was based on two guiding principles: quality assurance and utilization control. Through peer review, provider behavior and practice patterns can be changed. And this, we suggest, is to key to improving both the quality of care and affecting long-term savings.

We understand and we have heard this morning that the administration is giving consideration to contracting with fiscal intermediaries to perform utilization review as an alternative. We would stand opposed to this concept. If intermediaries are to avoid one of the greatest costs in peer review, that is, the data collection, they would have to use the billing information from claims forms to conduct such a review. We feel that is inappropriate and they would have to set up a whole new data base in terms of the medical information. We feel strongly that local provider involvement is essential to satisfy the need to assure that quality care meets the patients' needs.

However, if S. 2142 were enacted as currently written, it would repeal this delegation option. We speak in favor of retaining the delegation option because it does, as has already been indicated, offer an incentive to institutions, and it would offer the opportunity of not creating another duplication in the health care field. Whether we have the peer review program or not, hospitals, by regulation, by the Joint Commission of Accreditation Standards, will be doing utilization review. And I think those that do it adequately could well fit within the area of this bill.

We ask that there be some consolidation of review areas through the employment of an admissions-based formula. To the extent that S. 1250 takes into consideration both medicare and medicaid admissions, we prefer that there would be one system applying to both programs. We would urge that there be a population base or a total admission base for the determinations.

Designation of peer review organizations—we recommend that the language of this section prohibit the Secretary from contracting with payers of service for review functions. We have already touched on that.

Postdischarge care. As written, S. 2142 would allow only 2 days of payment to a hospital in cases where additional time was needed to arrange for post-discharge care. This is a situation beyond the hospital's control, at least in New York State, where we have had a moratorium on the construction of nursing home beds.

We would further point out to you that there is an opportunity here of coordinating this section of your proposed bill with the provisions of the Omnibus Budget Reconciliation Acts of 1980 and 1981 which addresses the situation by establishing lower rates of reimbursement for patients in alternate levels of care status.

The sanctions also give us some measure of concern. We would recommend that this section be amended to require that the Secretary act within 120 days of such a recommendation for sanction against a provider after it has been submitted to him. The suspension of participation in the medicare program could cause a considerable amount of problem here.

On focus review, we would prefer the previsions in S. 2142.

On medicaid review, S. 2142 provides that a State would be reimbursed 75 percent of their expenditures to the contracting agency to do peer review on medicaid patients. We believe this section should be strengthened to provide that States will be eligible for Federal reimbursement of review costs only if the contract is with a review organization designated by the Secretary.

That is our testimony, Mr. Chairman. We appreciate the opportunity to be here. We leave ourselves to answer any questions you might have.

Senator **Durenberger**. Thank you very much for your testimony. I thank all of you for being here.

The comments about medicaid suggest an observation at this point. As we go through the process of redefining federalism—I guess you are all aware of the President's proposal on trading off certain aspects of the public assistance program—it seems to me that the direction we are probably moving in is to federalize some portion of medicaid. There are some Governors that are proposing that we take on at the Federal level the elderly and the disabled and leave others at the State level. While I might have some sympathy for it as a notion, frankly I do not think that is necessarily an appropriate way to segregate society and necessarily perhaps come up with different levels of services.

So the direction we may go is to find a core set of benefits in medicaid, to federalize those along with medicare, and recognize the fact that you cannot federalize all of Government's involvement with the access of the poor, and disabled, and the elderly. In health care in this country, there are great values in State and local administered programs. I sense that the direction we are headed is to recognize that there will always be charity hospitals and there will always be a substantial burden in the health field at the local and the State level. For us to even purport to be federalizing that whole area is to fly in the face of reality.

So as we think through the best approach to peer review, I think that is an additional element that we have not gotten into here today and I do not intend to get into very far, but we ought to have in mind that this new federalism proposal will be here within another few weeks. It will be acted on, I am sure, some time before the end of this year. There may be some new relationships that develop as a result of that.

Let me ask you, Dr. Hotchkiss, about the AMA's position on peer review. Earlier this morning I talked with Dr. Weeks, the physician from Wheeling, W. Va., about the nature of his practice in the discussion of for-profit versus not-for-profit peer review organizations. It turned out that his private practice was for profit, and that he at least alleged that most physicians are in the business, in part to heal the sick and to keep people well, but also in part to make enough of a profit so they can sustain their families and so forth.

So, given that fact and given the fact that the money to heal the sick and keep people well and provide for your own family must come from somewhere. Looking at the health care delivery system and the financing system in this country we see that various people play various roles. Employers of people provide part of your profit. Insurance companies, through employers or through individuals, pay part of your profit. And the Federal Government and the State government pay for part of your services and therefore your profit.

I am curious to know why the AMA takes one position with regard to our buying services through medicare or medicaid and I assume another position with regard to insurers or employers buying those services. Or is your position that insurance companies and groups of employers should not put together and contract for peer review? Is your position that all peer review ought to be based in medical societies?

Dr. **HOTCHKISS**. Our position is that we are against federally controlled, federally mandated peer review. We are strongly in favor of peer review and have been for as many years as you can remember back. The first tissue committee, for example, in the world occurred in a U.S. hospital in 1919, and these committees have been there ever since. Tissue committees were in most all of the hospitals when I entered practice in 1951. We have many, many other peer review committees in the hospitals. We have utilization review committees which appeared in the late 1950's, blood transfusion infection committees, antibody committees, and as many other committees as you can think of conducting professional review. So we have been doing peer review for a long, long time.

Now as far as the for-profit issue, as I said in my statement, we are not for any kind of PSRO or federally controlled peer review. So, whether it is going to be for profit or otherwise, I do not really have strong feelings about it.

The PSRO in Tidewater, Va., which includes the Norfolk area, actually delegates this review work to the utilization review committees in 21 of the 23 hospitals. This indicates that the hospital staffs are doing a good job. Somebody said a while ago you could not trust the hospitals to do utilization review. It is not the hospitals that conduct such review; it is the doctors, the staffs in the hospitals, and they have a different viewpoint from the hospital administration.

So I do not think profit or nonprofit makes a whole lot of difference. The PSRO is authorized to pay the doctors who serve on the utilization review committees in the hospitals. I have served on a number of them over the years. I have yet to see dollar one. I have not looked for dollar one very hard because that is not where I make my living. It is such a small part of money anyway, compared to the practice of medicine, that I say well, if the hospital needs it, let them keep it.

Senator **DURENBERGER**. I trust you understand that what we are doing here is talking about a change in peer review. I mean clearly, as I indicated in my opening statement, we signaled last year the demise of the old system, the one that I think you described as

Federal involvement, Federal dictates, and Federal regulations, the system includes a section called 1155, which is restated in my bill as 1154, which deals with your statement. It deals with our invading physicians' offices to be inspecting them. I do not think we inspected any physicians' offices under the old section and I do not contemplate that we will under the new.

But the point of my using the for-profit illustration is that every once in a while those who pay the bill get dissatisfied with physician peer review. And let us say in the Twin Cities, in Minneapolis-St. Paul, to get away from Norfolk, Va., that this dissatisfaction leads large employers and insurance companies to get together and form a peer review organization of some kind, and the peer review organization is doing a pretty good job. It is starting to bring down utilization and cost to the employers and the insurers and they like it. They say this is a good deal.

Since we have 25 or 30 percent of the persons who are part of the health care system in the Twin Cities, should we not contract with that same organization for services?

Dr. **Hotchkiss**. I think you can contract with any efficient peer review organization that exists. Now since we testified before, our House of Delegates has passed a set of principles that indicates what would, we feel, make up an appropriate peer review committee. In addition, a peer review committee should have an organized structure, it should be continuous, educational, and it should maintain confidentiality and so forth.

We will consider at the board of trustees meeting here in April a further recommendation that would have the State societies, all the State constituent medical societies, proceed further to wrap this up in an organized peer review package.

Furthermore, the Joint Commission on Accreditation of Hospitals, which is a voluntary accrediting organization for hospitals in the United States, whose certification almost all hospitals seek, has a quality assurance program which wraps up the activities of these various hospital committees in a quality assurance program.

So there is motion going on in the private sector that will create organized, working, efficient private sector——

Senator **Durenberger**. Are you going to be at that April meeting?

Dr. **Hotchkiss**. I certainly will.

Senator **Durenberger**. OK. I just want you to understand where the author of S. 2142 is coming from. I have a responsibility for what the President said is $60 billion, and I guess it is actually more than that, worth of trust fund moneys that people are paying for. I am not anxious to have a bunch of Government bureaucrats or insurance company clerks out there making decisions for me in terms of what is appropriate utilization of services. I would rather have that done in the community or even on a statewide basis, by physicians.

So I have designed a piece of legislation that has the number of S. 2142 so that I know that in some fashion the community and physicians are operating in my best interest in discharging my responsibility. And I just want you to know that as you go into that meeting because as I read this statement which you were fortunate enough to be delivering on behalf of the American Medical Association, their view of this legislation and what we propose to do flies in the face of reality.

We are just trying to do what any responsible organization or individual would do, what insurance companies are doing, what groups of employers are doing by way of working with physicians in the peer review process. And we are just trying to set the ground rules for our own involvement so everybody understands it. That is how simple this is.

Dr. HOTCHKISS. Senator, I understand what you are saying and I appreciated your remarks at our leadership conference about 5 weeks ago, and I remember one of the principles you set forth was that the Government is a better purchaser of services than a deliverer of services, and you cited your bill to effect that.

I have tried real hard to read that into it and I have read your bill very carefully, and I just cannot in my own mind read it into it. Of course, I am not a lawyer. I do not have a legal mind. When I say that, some people say well, you must have an illegal mind. I do not know what kind of mind I have, but I cannot quite read that into it.

Now as far as the $60 billion. I would like to assure you that the American Medical Association is very, very concerned about this $60 billion and all other expenses, and we are trying to do everything we can to bring the cost of care under control, but I do not want to take up the time to go too far down that road.

Senator DURENBERGER. I would take just 1 minute to read into the record how S. 2142 fits into the statement of principles, and you might just take some notes on this. One of your first principles, "Medical peer review is an organized effort to evaluate and analyze medical care services', et cetera; I think if you look at page 7 of my bill you will find a lot of comparability there.

Your second one is "Medical peer review is a local process." If you look at page 3, lines 21 to 27, you will find that set out.

The third principle is "Physicians are ultimately responsible for all peer review of medical care." If you look at my legislation you will see an emphasis on peer review unless physicians refuse to be involved in the process.

Dr. HOTCHKISS. Or unless the Secretary says——

Senator DURENBERGER. And No. 4, the fourth principle you will find on page 2, lines 19 to 29, page 9, lines 13 to 19, page 11, lines 13 to 24, page 13, lines 25 to 32.

Principle No. 5 you find articulated on pages 6 and 7, line 27, on page 6, line 15 on page 7.

I could go on and I will for the record, but the——

Dr. HOTCHKISS. Could we get a copy of those? I could not get them.

Senator DURENBERGER. You bet. I appreciate your patience with my patience with the AMA today. And I have a lot of patience because you are a key part of this system, and we are going to come together on this one sooner or later.

Dr. HOTCHKISS. We want to work with you on it.

Senator DURENBERGER. Great. Thank you very much.

I wonder if it would be appropriate to ask the other two witnesses to help me in some way to encourage the AMA, and I know your testimonies are somewhat different in your view of S. 2142, but perhaps, Dr. Zamostien, you could make some comment about where they ought to be headed.

Dr. **Zamostien**. Well, it is very difficult, of course, for me to say what the AMA should do. We are certainly involved in local situations, rather than just only national situations. And in Pennsylvania, I have been on a PSRO board for 6 years, as I mentioned.

At this time, I would like to introduce Mr. Stephen Keys, who is the executive director of our Pennsylvania Medical Care Foundation.

In Pennsylvania, we certainly have involved ourselves in local areas. I have been serving on a PSRO. I serve on the review committee in our hospital. Yes, I think we need peer review. We need it very badly.

I think that the peer review has to be done by physicians. As mentioned in one of the previous testimonies, yes, we do employ the services of nurse coordinators to help us out, but the eventual decisions are being made by physicians, and we are in favor of that.

As far as whether you want to call it PSRO or MGQ or whatever you want, I do not care what you call it, but we do have to have peer review and the medical profession, and I can certainly speak for Pennsylvania, is definitely involved in it and wants to be. We have our little areas where we have to talk to somebody and talk them into it, but generally speaking physicians are willing to have peer review by physicians.

Senator **Durenberger**. Monsignor Fitzpatrick?

Monsignor **Fitzpatrick**. I have been trying to light that candle for 34 years that I have been a hospital administrator, Senator. I think perhaps the stimulus that I give is a disincentive, and it is the history we had in New York State. The State imposed an onsite nurse to declare the appropriateness of that patient being in the hospital. Now you can imagine the conflicts that administrators went through with an inhouse Gestapo nurse going after the medical profession.

Senator **Durenberger**. OK. Thank you all very much. We appreciate your taking the time to be here.

The hearing is concluded.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

April 9, 1982

Statement of

The American Association of Oral and Maxillofacial Surgeons

for

Committee on Finance
Subcommittee on Health
United States Senate

Regarding Proposals to Make Improvements in Professional Standards Review Organizations

In the Omnibus Reconciliation Act of 1980, Congress took a much needed and important step toward facilitating the participation of dentistry, and its specialty, oral surgery, in the peer review process. Each PSRO was authorized to offer membership to dentists who hold independent hospital admitting privileges. AAOMS urges this Committee at least to preserve participation by dentistry in the current re-evaluation of PSROs. In any reorganized structure the Committee may establish, the Committee should further assure that dentists participate fully in any review of their peers.

The members and staff of AAOMS will be pleased to consult with the Committee's staff concerning appropriate procedures to fulfill the foregoing principles.

Respectfully submitted,
RAB
Edwin S. Cohen
Richard A. Brady
Counsel for AAOMS

Statement of
INTERNATIONAL CHIROPRACTORS ASSOCIATION
AND
AMERICAN CHIROPRACTIC ASSOCIATION
submitted to
Health Subcommittee,
U.S. Senate Finance Committee
April 2, 1982

The International Chiropractors Association and the American Chiropractic Association together represent approximately 23,000 practicing chiropractors in the United States. Dr. Ronald Beideman, a chiropractor, serves on the Department of Health and Human Services' National Professional Standards Review Organization Advisory Council. We certainly appreciate having this opportunity to express our views on PSROs before this Committee.

In 1972, the PSRO program was created under P.L. 92-603 for the purpose of assuring that health care services delivered to Medicare and Medicaid patients are necessary, appropriate and of acceptable quality. Perhaps the purpose of this program can be summarized by a statement delivered by Senator Wallace F. Bennett on the floor of the Senate, just prior to the passage of the PSRO legislation. Senator Bennett said:

> "The PSRO amendment represents the best and perhaps the last opportunity to fully safeguard the public's concern with respect to the cost and the quality of medical care."

The ACA and ICA realize that health costs have been skyrocketing over the past few years. The Federal Government is currently searching for ways to reduce health expenditures via such options as block grants, competition proposals, program cutbacks, and elimination. While we strongly believe that wasteful federal spending in all areas including health should be eliminated, we do not believe that spending for PSROs should cease.

The problem of rising health costs is highly complex and cannot be solved by any "quick fixes or easy solutions." At this time, it is our understanding that not all of the 147 PRSOs currently functioning in this country are cost-effective. But the majority of the PSROs are cost-effective and their wholesale elimination would prove "penny wise and pound foolish."

The ICA and the ACA support the continued funding of those PSROs which are cost-effective. For example, according to the New York Statewide Professional Standards Review Council, Inc., PSROs in New York State saved a characteristically tight state budget over $5 million in 1980. The single PSRO in the state of Montana, while doing utilization review for hospitalization under Medicare, shortened the average hospital stay by ½ day in 1979 according to the Montana Foundation for Peer Review. This change reduced the number of overall days spent in the hospital by 19,000. Hopefully, successful efforts such as these can be duplicated in other states.

Besides supporting the specific legislative proposals in this area, we also support the government's continued role in the area of hospital utilization peer review. We do not believe that a voluntary peer review would be in the best interest of the general public or the various provider groups. The ICA and ACA strongly recommend that any legislation pertaining to hospital utilization review include specific language mandating representation of alternative provider groups and health oriented consumer groups. We believe this will also help peer review to function more effectively.

The ICA and the ACA support the goals of the legislation introduced by Senators Durenberger and Baucus. Specifically, certain parts of S.2142 and S.1250 warrant a more in-depth comment.

We believe that the provisions contained in both bills which would allow the Secretary to terminate a PSRO after 90 days of operation is an excellent method to help promote efficiency in the actual administration of PSROs. The 90 day period allows the Secretary to quickly eliminate an ineffective PSRO and solicit another which is better qualified.

We believe the proposal in S.2142 which defines Utilization and Quality Control Peer Review Organizations should also mandate that alternative health care providers and other health related consumer groups be represented on all hospital utilization review groups. We believe that a diversity of qualified health care viewpoints are necessary to effectively review hospital utilization. For example, there have been many reported instances of chiropractic care helping an individual to avoid major back surgery and long-term hospital care.

We have some concern with the proposal in S.2142 that private (for profit) organizations should be allowed to compete for PSRO contract agreements. While we want to help promote a greater efficiency among PSROs, we feel that these review organizations must include strong representation from their peer group.

We support provisions in S.1250 which count hospital admissions under both Medicare and Medicaid for the purpose of determining a peer review area. We believe this method of determination will lend itself to producing a more realistic peer review area.

We are committed to the concept of peer review. The cost control battle continues and PSROs and UR systems are demonstrating some effectiveness in controlling this difficult area. The system's focus however must be on quality care and then on cost. Appropriately in a "review" situation of a health care provider, the scrutiny must be from the health providers' peers. This is a very important factor. A substantial number of doctors of chiropractic should be appointed to any review group scrutinizing a chiropractor's services in order to assure adequate peer review. We also welcome health care consumer representation as well.

This committee is concerned with developing a peer review system which focuses its attention on strengthening the actual review and also attempts to reduce any burdensome regulations to those being reviewed. This is in keeping with the Reagan Administration's desire to relieve the federal government from excess regulation.

S. 2142 does address other problem areas thereby clarifying the objectives of the total program. Specifically we support the restriction disallowing insurance companies from being named review organizations. The health care provider group being reviewed must be judged by its peers.

Presumptively the task of this body is to find a careful balance between the delivery of quality health care and controlling the cost of the federal government's financial support (as it is an employer and participant) in the system. Likewise the retention of the basic theme of the current PSRO law (while moving to a deregulated basis and thus allowing more competition) is difficult yet designed to serve the needs of the public more efficiently.

The public record reflects that the ACA and the ICA have been committed to improved competition in the delivery of health care for many years. Similarly we have had a long standing concern for the "quality" of the care which is delivered. Appropriately S. 2142 seeks to address these specific issues. Surely it is agreed that the proper role of a PSRO is to develop a system of quality assurance while at the same time keeping a watchful eye on the cost factor.

Mindful that the principle reasons cited for dropping the PSRO program was the desire to reduce federal regulation and increase competition, one must be equally aware of the tremendous pressure to contain the escalating costs of delivering health care. Individual employers and management are cognizant of the ever increasing cost of health care benefits. The federal government as a major provider of health benefits is acutely aware of this fact and must be equally concerned. The diligence of this committee to continue searching for methods to control the problems currently facing the delivery of health care on a cost-conscious basis is appropriate.

It would not be a prudent or adequate suggestion to recommend the dismantling of the peer review organization structure now established. In order to make that recommendation one must offer an alternative system that would more efficiently handle the problems that PSROs were originally designed to resolve. PSROs came into existence to meet the shortcomings of voluntary self-regulation. To return to that situation with the additional difficulties facing the health care system today is not realistic.

The federal government must be able to obtain a "handle" on the ever escalating costs of delivering health services. Growing hospital costs threaten to undermine the health economy just as the gas crisis affected the economic welfare of the whole economy. Together we must search for ways to provide effective health care services efficiently. We look forward to working with this committee and its staff in its efforts to address this situation.

April 1, 1982
SENATE FINANCE COMMITTEE
Subcommittee on Health

Hearings on Proposals to make Improvements
in
Professional Standards Review Organizations (PSRO)

MONTANA FOUNDATION FOR MEDICAL CARE

Testimony in Support of Professional Physician Peer Review
Presented by:

John W. McMahon, M.D., Medical Director, Montana Foundation for Medical Care
Janice Connors, Executive Director, Montana Foundation for Medical Care

SUMMARY OF MAJOR POINTS:

I. Effect of Peer Review in Montana

The Montana Foundation for Medical Care has demonstrated the impact of review activities on the federal patient population. We have also had reports from the private insurance carriers that they observed the same beneficial impact in their population groups. This effect should be studied to demonstrate the total impact of peer review in an area.

II. Suggestions for Better Defining Health Care Costs and Reimbursement Schemes

A. Study cost/benefit ratios of expensive health care technology and procedures versus increased productivity of patient.

B. Separate the utilization of long term care facilities into medically-related care and socially-related care. Determine the appropriateness of utilizing health care dollars for meeting social needs and develop proper support for the separate issues.

C. Place a high priority on developing regulations to implement the swing bed concept.

D. Establish additional level of care guidelines and reimbursement schemes to support rehabilitative services.

III. Durenberger Bill

The Montana Foundation for Medical Care is supportive of this bill with suggested modifications.

IV. Improvements Needed in Sanction Process

Decisions regarding the appropriateness, necessity and quality of care should remain the exclusive realm of the reviewing peer physicians. The review and approval process should be restructured to decisions of due process.

I am Dr. John McMahon, representing the Montana Foundation for Medical Care. The Foundation is the Professional Standards Review Organization for Montana. In a nationwide assessment last year by the Department of Health and Human Services, it was judged 7th highest of all 182 PSROs. Industry has learned that the control of product or service quality is vital to corporate strength and public image. Lessening or absence of control leads to failure. The same analogy applies to the medical care field. Physician peer review, through the Professional Standards Review Organization, is the keystone of quality medical care. I am a strong advocate of physician peer review. I have been active in the Montana Foundation for Medical Care since its inception nine years ago. It has been two years since representatives of our group have appeared in Washington. Many changes have occurred in our nation's economy since that time. It is our desire to give the people of this country a dollar's worth of quality medical care for every dollar spent. We are very concerned that, in the area of peer review of medical care, regulations are overtaking the intent of the law.

As very clearly pointed out by Senator Durenberger when he introduced his bill for the continuation and reinstitution of physician peer review in the Medicare program, the worst assessment of the PSRO program has demonstrated that the dollars saved equal the dollars spent. Again, may I point out that that is the worst assessment and that assessment was performed by the Congressional Budget Office.

We should like to illustrate several findings that were not identified in that assessment. Our experience in Montana has very clearly demonstrated that when we were doing concurrent review of hospitalized patients through June of 1979, the average length of stay under the Medicare program in Montana fell by one-half day per patient. This represented a savings of 19,000 days of care in one year. Because of budgetary cuts imposed by the Carter administration at that time, we were forced to go to a retroactive review of patients' records. As a result, the average length of stay increased by greater than the half day savings we had achieved. Because of this experience and in spite of even further budgetary cuts, we streamlined our administration and went back to concurrent review in our major hospitals in July of 1981. Within six months, the average length of stay in the Medicare program declined by 0.11 days. We expect this trend to continue. Our average cost of hospitalization in the state is $235.00 per day. We realize that there are some ongoing expenses in the Medicare population even if the bed is vacant. However, it is clear that concurrent review of hospitalized Medicare patients achieves significant cost savings.

To us, an even more striking and significant trend has been the finding by Montana Blue Shield and Blue Cross of Montana of an associated decrease in utilization of hospital beds when we were doing concurrent review. Again, they saw a similar parallel increase in length of stay when we went to a program of retroactive review. These organizations have strongly supported the Foundation's program because of the spinoff benefit they observed in their private pay patient group. To our knowledge, none of the national surveys have looked at the indirect effects of concurrent review on other population groups. The attached graphs demonstrate this effect across several programs in individual facilities.

Everyone likes to keep as much of his paycheck as he can. A significant amount of that paycheck is deducted either by direct employer or employee contribution to health insurance. Active, effective, and expert peer review is, in our judgment, the greatest single contribution that can be made by government and private enterprise to insure cost effective delivery of medical care and protect disposable income. We see numerous articles expressing a desire to cut the costs of medical care. The cost of medical care will parallel the rising costs in inflation. We can take better care of more people and prolong productive life in ways that are immeasurable. None of the studies critical of the cost of medical care address the increased productivity of the patient whose life is prolonged by the costly end stage renal disease program, or costly coronary artery bypass, or costly organ transplantation. Somehow, the citizens in this country, and the government, benefit directly from the increased productivity of patients under these programs. National statistics have demonstrated that the life expectancy of a 54 year old man in the United States has increased four months per year since his birth. That is a direct result, for the most part, in improvements in medical care. What we can do as peer physicians is to assure that the dollars being spent on health care are being spent appropriately and necessarily.

It would be possible to redefine some of the items that are now included in the national health care bill. In our judgment, some of these items are social issues. We refer most explicitly to the increased numbers of patients in long term care facilities. In our judgment, many patients in Montana are placed in long term care beds for social reasons. Had these same people had an opportunity to live either at home with some minimal outside support, or in a family setting, they would not need long term care. In our judgment, this is a social placement. It is not a necessary health care expenditure.

As the present administration's proposal for federal management of Medicaid is carried out, we expect a great upheaval in the placement of some of these patients. We express our concern at this time only to alert Congress in advance of the significance of some of these issues. To be absolutely precise, it is only medically necessary that a patient be placed in a long term care institution if for strict health care reasons they cannot be managed in a lesser setting. Again, our experience in Montana would indicate that a significant population in our long term care institutions could be managed at home if an appropriate home were available, either through the family or some social agency. It is not, in our judgment, an appropriate expenditure of health care dollars when such patients are placed in long term care facilities for other than health care reasons, and the bill is paid by Medicaid.

We would encourage you to advise the administration to proceed with writing regulations which would implement the swing-bed legislation. In one Montana community at the present time, long term care beds are simply not available. We see waiting periods up to 32 days, in one instance, for placement. We realize that federal programs have mandated nonsupport of such patients in acute care settings, if a long term care bed is available within a 100 mile geographic radius. Conceptually we question whether or not many of you realize what this means. It may assure a loss of continuity in physician care for that patient. Unfortunately, many families do not visit their loved ones in long term care institutions with any regularity, even when that long term care institution is within a mile or less of the family's home. In most instances, much of the visiting is done by friends, who are also elderly and frequently partially disabled. A mandate of 100 miles may mean total isolation of the patient from loved ones and friends. How many Washington, D.C. residents would like to be placed in New York City, or Boston, or Baltimore, or Philadelphia? If the swing-bed concept is realistically implemented, the care of these patients could be paid for in the acute care setting at a level equal to that which would be spent in a long term care setting until a local bed is available. This will not only save health care dollars, it will give continuity of health care in an environment in which a patient can still be visited by their loved ones and friends. It is good medicine and it is humane. It was good legislation. It should be implemented.

We have also experienced multiple problems in our review in classifying chemical dependence rehabilitation patients and physical rehabilitation patients. We are limited to the three classifications of acute, skilled and intermediate care. We need the flexibility to classify these patients as to what they are - namely rehabilitation patients - and let society, through private carriers and governmental agencies, determine appropriate remuneration to the facilities involved. We do believe that this care is necessary and that we have the expertise to certify the necessity for such care in individual patients and to insure that it is offered in an appropriate setting.

We strongly support the Durenberger bill. We have submitted to our national organization our comments for suggested modification of this bill. We strongly believe that any organization given a contract to assure quality and appropriate utilization must be a nonprofit organization with broad physician support. We would hope and expect that physician organizations (such as the Montana Foundation for Medical Care) who have successfully contracted with the PSRO program, would be given prime consideration under the new program.

The assurance of confidentiality under the Durenberger bill is commendable.

We are concerned that those who write the regulations based on the Durenberger bill may again write regulations regarding norms, standards and criteria that may cause major problems at a later date when sincere physician groups are attempting to peer one another. Some have assumed, and we have some bitter experiences in Montana, that the original PSRO legislation mandated that a "cookbook" be written to cover all aspects of health care. This is impossible. Medicine is not an exact science. Norms, standards and criteria can only be used for screening purposes in the specific management of a patient and a specific instance can only be based on the physician's experience and his knowledge of current literature. When this is expanded to include the experience and knowledge of current literature by his peer colleagues, the patient can and will be best served. An all-encompassing document that could cover the appropriate diagnostic evaluations, ancillary services and evaluations about any specific patient's illness and then progress on to specific best possible treatment, is not now nor ever will be available.

A significant proportion of the physicians in the United States have demonstrated that they are capable of insuring that citizens receive the best possible medical care in the most cost effective manner. We would like to see legislation supporting PSRO decisions on the appropriateness and necessity of care made by these peers. We have had some bitter and frustrating experiences *in the sanction process. In one instance we were told* that the physician's records were so poor that we could not determine whether or not the physician in question was giving quality care. For this reason, a sanction recommendation which we made was disallowed by the federal government. The federal government took this position in spite of the fact that numerous peer physicians advised that the Medicare and Medicaid patients in our state would be best served if this physician were no longer certified for payment purposes under the Medicare and Medicaid programs.

Peer physicians decided that the public would be best served if the sanction was imposed, but bureaucratic nonphysicians decided that the peer physician could not make that recommendation because the physician's records were so bad. Adequate records is a quality issue. It is most important for my patients that I dictate adequate notes that will allow future physicians to know exactly what I did and why I did it. When government pays the bill, peer physicians must be assured that that money is being spent appropriately. Unless my records are adequate and readable, I am not serving my patients appropriately. When physician peer groups, after very careful review and exhaustion of all other avenues to change the physician's inappropriate practices, decide that the public would be best served by elimination of reimbursement to that physican, then we would expect the agents of the federal government to be supportive. The MTFMC has recommended such sanctions on three physicians and in each case the federal government dropped the sanction. The determination of what is and what what is not good medical practice must be made by peer physicians and not by nonphysician agents of the federal government.

Our prime interest remains quality assurance. When representatives of the Foundation appeared in Washington in support of peer review in Senator Mansfield's time, we very clearly stated that our prime interest was insuring quality care for all of our patients. We have oriented all of our programs in this direction. In our judgment, utilization review continues to be a quality issue. We have taken upon ourselves the responsiblity to assure that health care dollars are spent, insofar as possible, only for necessary care.

I must emphasize that we believe that the biggest mistake we could make would be to deny necessary care to any patient. The economic environment is even more severe now than it was when we were first here. We remain concerned that, because of financial realities, some patients may be denied necessary care. We will do all we can to prevent any such occurrence.

We have done our best to serve the public and assure the availability of quality health care for all our citizens. We have done this only with the blessings and encouragement of this committee. We welcome the opportunity again to apprise you of our successes, as well as our difficulties. We continue to look forward to a mutually supportive role with government in assuring the citizens of this country good medical care. There is little question about whether the patients in the United States have the best medical care. The question that remains is whether or not we can afford it. It is our belief that the best medical care is affordable if the advice and recommendations of strong physician peer groups are heeded by the federal government.

Thank you.

AMERICAN HOSPITAL ASSOCIATION
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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION TO THE SUBCOMMITTEE ON HEALTH OF THE SENATE COMMITTEE ON FINANCE ON S.2142 "PEER REVIEW IMPROVEMENT ACT OF 1982"

April 1, 1982

The American Hospital Association (AHA), which represents more than 6,300 member hospitals and health care institutions, as well as more than 35,000 individual members, is pleased to have this opportunity to present its views and recommendations on S.2142, the "Peer Review Improvement Act of 1982," introduced by Subcommittee Chairman David Durenberger and Senators John Heinz and Daniel Patrick Moynihan.

AHA understands the intent of the legislation - to streamline and improve the ineffective and needlessly costly Professional Standards Review Organization (PSRO) program. However, we believe that federally mandated peer review is neither appropriate nor effective in controlling costs or assuring the quality of health care services. In our view, the most effective peer review system is one initiated and funded at the local level by the private sector, voluntary organizations and local governments and carried out by the individual hospitals.

The AHA House of Delegates last year withdrew its previous support for PSROs and adopted its present policy supporting repeal of the PSRO law. AHA's policy is based on the belief that the PSRO program has not been cost effective, that it has not made an appreciable contribution to quality of care as originally envisioned, and that it has bound many hospitals in red tape. The PSRO program has tried unsuccessfully to impose a uniform utilization review and quality assurance structure on activities that are best performed at the local institutional level. Well-functioning hospital patient care appraisal committees can ensure that care provided to patients is of high quality, appropriate duration, and is rendered in the appropriate setting.

The AHA policy on PSROs is a rejection of an ineffective federal program, not an abandonment of our commitment to assure the quality of care patients receive in our nation's hospitals. AHA's policy resolution links PSRO repeal with concerted action by the AHA to assist member hospitals in upgrading their patient care appraisal capabilities where such deficiencies exist. An AHA program, "Quality, Trending and Management for the 80s (QTM)," is one example of this assistance to hospitals. QTM is a series of national educational programs and on-site technical assistance programs designed to help hospitals organize and manage their quality assurance programs. Other programs have been instituted, including one focusing on management theories for improving employee morale and productivity, and another which provides detailed quality assurance guidance at the departmental level of the hospital.

Last year, the AHA House of Delegates also adopted updated policy and guideline statements on quality assurance and utilization review in health care institutions. According to these policies, health care institutions should conduct quality assurance programs, including mechanisms for establishing standards for proper health care that are appropriately and reasonably consistent with those developed by professional, accrediting, and governmental bodies, to determine the quality of care being provided and to correct identified deficiencies. Health care institutions should also evaluate the medical necessity, appropriateness and efficient use of health care services and facilities for all patients as a means of improving the cost effectiveness of the health care delivery system.

We are convinced that utilization review and quality assurance activities will not diminish in the absence of federal mandates. There are numerous incentives for hospitals to perform these functions. The Joint Commission on Accreditation of Hospitals (JCAH), which accredits 5,000 institutions, includes both utilization review and quality assurance standards in its criteria for accreditation. JCAH standards require an organized, integrated quality assurance program developed pursuant to a written plan, ongoing objective assessment of patient care, and correction of identified problems. JCAH intends to maintain these standards for accreditation regardless of the presence or absence of utilization review requirements in the Medicare law.

With the removal of federal mandates, the private sector and local governments will take the initiative in utilization review and quality assurance where they perceive the need. More than 80 community-based health care coalitions have sprung up around the country. Businesses and labor groups are recognizing common interests in controlling health care costs and are becoming increasingly involved in local coalitions. These activities promote innovation and flexibility in response to local needs in the health delivery system. Incentives for hospitals to perform utilization review will be further increased as competition is introduced into the health care system.

Provisions of S.2142

While we support repeal of the PSRO law and oppose any legislation that would continue a federal role in peer review activities, there are specific provisions of S.2142 which we believe we must address because of their implications for hospitals.

Delegated Review

S.2142 would eliminate the authority of a peer review organization to delegate review authority to a hospital. As previously stated, AHA believes that utilization review is most effective when performed at the institutional level. Those responsible for decisions affecting the care of patients in hospitals also must be responsible for evaluating the medical necessity for, and the quality of, that care. Utilization review is most effective when incorporated in the education of medical staff. Professionals are more receptive to the findings from quality assurance activities when these activities are performed by the hospital and its medical staff.

Elimination of delegated review also would result in unnecessary duplication of review activities and unnecessary additional costs to the health care system. Hospitals will continue their own utilization reviews and quality assurance programs to meet JCAH accreditation and their own legal and ethical commitments to ensure the appropriateness and quality of health care services, regardless of requirements imposed by federal regulation. Failure to recognize and make use of these existing review systems is both wasteful and costly.

The assumption that hospitals cannot review themselves is unfounded and based on a misunderstanding of hospital practices, policies and accountability in this area. For example, Deere and Co., which has used private peer review programs for its extensive health benefits program, has found that peer review organizations using delegated review are effective. In its contract with the Iowa Foundation for Medical Care, which uses delegated review, Deere reported a 21.4 per cent reduction in inpatient days per 1,000 insured persons; a 15.3 per cent drop in admissions per 1,000; and a 7 per cent reduction in average length of stay for the contract period January 1978-September 1981.*

*Source: Mr. Duane H. Heintz, Manager Health Care Service, Deere & Co., Moline, Ill., Telephone Interview, April 2, 1982.

Imposition of Sanctions

S. 2142 would automatically suspend a provider from the Medicare program if the Secretary did not act within 120 days on a peer review organization's recommendation for suspension. Because suspension from the program would amount to a loss of significant rights, it should only result from affirmative Secretarial action accompanied by adequate procedural safeguards. While the legislation sets up review procedures for cases in which Secretarial decisions are challenged by a provider, it is unclear whether these or other avenues would be available after a suspension by Secretarial inaction.

Private Patient Data

S.2142 would require providers, upon request, to release data on non-Medicare patients to peer review organizations that have contracts for review with private and public agencies. This requirement is neither relevant nor necessary to the operation of the Medicare program. The terms and conditions of the release of such information should be negotiated by hospitals and payers under applicable state privacy laws, not mandated by the government.

Post Discharge Care

S.2142 seeks to limit to two days the Medicare-paid time available for making arrangements for post-discharge care when inpatient care is determined inappropriate. It would impose an unrealistic time frame on hospitals, unfairly penalizing them for the shortage of long-term care beds, a situation beyond their control. In these circumstances, patients could be left without needed care because of an arbitrary rule.

Confidentiality of Information

AHA supports the provision of S.2142 which clarifies that peer review organizations are not federal agencies subject to the Freedom of Information Act. However, resolving that question alone does not overcome larger problems in the PSRO program regarding disclosure of medical information. Hospitals experience with PSRO's has revealed continuing problems with unnecessary disclosure of information. We note that the provisions of S.2142 relating to confidentiality closely mirror the current statute and may perpetuate these problems.

Development of Evaluation Criteria

AHA believes that the legislation should specifically require that hospitals have an opportunity to participate in the development of the evaluation criteria to be included in the contracts with review organizations.

Conclusion

AHA supports repeal of federal PSRO legislation. S.2142, while attempting to improve the PSRO system, continues the unnecessary federal mandate for peer review and could create new problems for hospitals. AHA is committed to vigorous quality assurance and utilization review activities at the level where they can be most effectively performed - in the institution. Thus, we continue to support efforts to develop local utilization review and quality assurance mechanisms that will serve the needs of all patients.

We thank the subcommittee for this opportunity to present our views and would be pleased to provide any further information or assistance that its members might request.

April 1, 1982: Hearing on Proposals to Make Improvements
on Professional Standards Review Organizations (PSRO's)

Area
PROFESSIONAL STANDARDS REVIEW ORGANIZATION
22

WRITTEN TESTIMONY OF LEON BENDER, M.D.

Area 22 PSRO is located on the west side of Los Angeles County. There are eleven acute care facilities and two specialty hospitals within the boundaries of Area 22.

Area 22 PSRO is a small, efficiently run review organization. In 1980, operating on a budget of close to $500,000, Area 22 saved the government over $1,500,000 in Medicare costs. The cost-benefit ratio was greater than 4-to-1.

In 1980, Area 22 was ranked first among PSROs in Region IX which covers California and three other western states.

We have just completed our impact document for 1981, and once again Area 22 has proven to be cost-effective. Not only did we meet all of our current objectives, but we initiated several sanction activities. First, we recommended that action be taken against a physician who continued to authorize procedures not covered by Medicare. We recommended, to the Secretary of Health and Human Services, to exclude this doctor from Medicare coverage for two years. Currently we are fighting his appeal in court.

Second, we de-delegated a hospital that had continued problems in its utilization review process. At the same hospital we have recommended that action be taken against a particular physician who twice performed non-covered procedures that resulted in complications leading to death.

Third, we continuously notified one area hospital that its quality of care was not up to area standards. Finally the hospital was taken over by a Health Maintenance Organization, and by working closely with the facility in a non-delegated mode, the hospital has improved its quality of care. The percentage of unnecessary days in this hospital was reduced from 7.77% to 1.23%.

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Fourth, in one specialty hospital where a relatively high number of patients had lengths of stay greater than 28 days, we have informed the hospital that physician progress notes are required at least three times a week. Unless this stipulation is quickly met, we will take action against the hospital.

Fifth, in one area hospital we found severe problems in its decubitus unit. We rebutted waiver of liability for this diagnosis, which accounted for a large percentage of their patient load. In March, the hospital was closed down.

Sixth, in one area hospital there were problems with too few physician advisors for review, several incidents of inappropriate use of the Acute Rehabilitation Unit, and many instances of delays-in-service. Working closely with the hospital, these three problem areas were rectified.

In addition to achieving all our stated goals and initiating sanction activities, Area 22 is a leader in the community. Here is a list of last year's community activities:

--Area 22 co-sponsored a regional seminar along with the American College of Utilization Review Physicians.

--Area 22 sponsored an areawide Review Coordinators Advisory Group. A subsidiary group, the Area 22 Acute and Skilled Nursing Facility Task Force, began meeting this year.

--Area 22 PSRO participated in seminars with the Advocacy Alliance for Aging Patients, whose main goal is to improve the quality of care in Skilled Nursing Facilities.

--Area 22 has organized groups from the Health-Care-Practioners-Other-Than-Physicians community to set standards for health care.

--the Pharmacy Committee of the PSRO has developed guidelines for IV Therapy programs and has conducted a survey on the problem of overutilization of Cimetidine.

--Area 22 PSRO was one of ten nationwide PSROs to be contacted for information on elderly patients for a study by Robert Kane, M.D., of the Rand Corporation.

--Area 22 PSRO conducted a Migration Study to determine the actual number of patients in each area taking migration into consideration. Results were presented to all Los Angeles County PSROs.

--Two doctors from Argentina came to visit Area 22 PSRO in order to learn how to set up a similar utilization review system back in Argentina.

In short, Area 22 PSRO is an active leader in the community as far as health care education is concerned.

One would think that Area 22 PSRO, with its number one ranking in Region IX, its track record of cost-effectiveness, its list of sanction activities, and its involvement in the community--one would think that Area 22 PSRO would be a model for what a PSRO should be.

And yet the proposed legislation (Bill S.2142) threatens to wipe out Area 22 PSRO--and other small, effective PSROs like us. In fact, incredible as it may seem, the bill, if passed, would bring a quick end to 16 of the top 25 PSROs!

One cannot help but feel that something is awry in this proposed legislation, for how could a proposition that is supposed to make the PSRO program more efficient and less costly threaten to wipe out the cost-effective PSROs and replace them with less effective PSROs.

Can it be that the bill's proponents didn't do their homework? The logic behind the bill is simple: as long as there is a Medicare program, there needs to be utilization review to ensure that hospitals don't extract unreasonable Medicare sums. Hence the need for the PSRO program. Yet the Administration (the same administration that recommends de-centralization wherever possible) wants to cut the PSRO program. So the bill proposes that there be fewer PSROs. Simple enough.

But the bill chooses to reduce the number of PSROs in such a way that the more effective ones would be wiped out. The PSRO program would be much less cost-effective (though the total dollars spent would be less), and in a short time, the efficiency of the program would be so inadequate that those inclined to argue against the need for peer review would have an easy time rationalizing the complete defunding of the PSRO program.

The bill states that, if possible, one PSRO will take on review responsibilities for an entire state unless the state has so many annual Medicare discharges that this is unfeasible. Then the state shall be divided into areas, with no area having fewer than 75,000 annual Medicare discharges.

What follows is a list of the top 25 PSROs according to performance last year. Of the top 25, only 5 had more than 75,000 discharges. It should be obvious that the larger the PSRO, the less efficient it tends to be.

If the PSRO program is to be altered, it shouldn't be changed in a manner that will guarantee its demise--especially when the smaller, more efficient PSROs have proven that the PSRO program can be quite effective!

What we recommend is that tighter guidelines be placed on PSRO performance. Those PSROs that fail to meet these guidelines will be defunded and those areas that open up will be covered by expanding neighboring, successful PSROs or private review organizations where no PSRO exists. Why punish the successful

PSROs simply for being small? Reward them--by giving them contracts for areas where previous review bodies have been unsuccessful.

The overall tendency in the PSRO program must be to weed out the bad PSROs, and encourage the good PSROs by allowing them to not only continue to do review but giving them the chance to expand into those areas where a void exists in the effective review geography.

The start-up costs of removing an effective PSRO and replacing it with a novice review organization would be staggering--and senseless.

The PSRO program must be saved by more rational means!!!

April 1, 1982: Hearing on Proposals to Make Improvements
on Professional Standards Review Organizations (PSRO's)

Area
PROFESSIONAL STANDARDS REVIEW ORGANIZATION
22

WRITTEN TESTIMONY OF EDWIN W. BUTLER, M.D.

The Area 22 PSRO, located on the west side of Los Angeles, is a small, effective organization. In 1980, its ten employees administered over 90 million dollars for 33 thousand Medicare admissions to thirteen hospitals. In a recent national ranking for PSRO effectiveness by the Department of Health and Human Services, we were rated #1 for Region IX and #19 nationwide. We hope to show that not only is a smaller PSRO more likely to be cost efficient, but also that it is better able to improve the quality of health care and to be responsive to its particular community.

Our 1981 Annual Report listed four successfully implemented objectives, which together cut back unnecessary medical procedures and hospitalizations at a cost benefit of over one and a half million dollars.

1) We reduced the rate of unnecessary retrograde pyelography in patients undergoing diagnostic cystoscopy in three hospitals by 6.8% (estimated cost savings $4,800.00).

2) We reduced the average length of stay for diabetes mellitus by 2.3 days (21%) in our eleven non-specialized hospitals (estimated cost savings $50,000.00).

3) We reduced the average length of stay for cholecystectomy in four hospitals by 2.5 days (15%) (estimated cost savings $69,102.50).

4) We reduced the rate of patients admitted with the diagnosis of decubitus ulcer by 75% in all our hospitals (estimated cost savings $1,425,938.00).

These four objectives alone saved over four times last year's budget.

In general, we believe that smaller PSROs are more likely to produce cost savings of this type for the following reasons:

1) They are better able to focus in on the particular physicians, hospitals,

or procedures that need improvement. The inevitable blanket monitoring a large PSRO will have to maintain will waste time and money focusing attention in places where there is no problem.

2) They are better able to keep a close surveillance on physicians and hospitals, because they have more time to focus attention on them. In a large PSRO, if the cat is 500 miles away, the rodents are more inclined to play.

3) They have more time to spend on implementing actions for improvement rather than gathering data. Because there will be that much more to obtain and assimilate, a large PSRO will inevitably be more bureaucratic, more inclined to red tape and less effective a watchdog.

However, cost effectiveness is only part of the picture. The Area 22 PSRO has also made dramatic inroads in improving the quality of health care at the facilities under its jurisdiction.

As examples, we have reduced the mortiality rate of surgery involving cholecystectomy by 71.42% and have reduced the mortality rate of surgery involving endarterectomy by 34.62%.

These reductions occurred because time could be taken not only to analyze the problem and set goals, but also to get involved with what actually had to be done to make improvements. A large PSRO may not have the time to concentrate their attention on the particular hospitals and physicians that needed more assistance.

We also believe that a localized PSRO will be more able to interact with and respond to its community. Of the 4,000 Area 22 physicians, 1700 belong to the PSRO with 100 actively engaged in committee work. This means that the PSRO is more than just a professional intrusion in the lives of our doctors, but a personal element, either through direct participation or by contact with an active colleague.

The Area 22 PSRO has also succeeded in reaching out beyond hospital walls and doctors' offices. In 1981, our Annual Report cited the following instances of community involvement.

1) We co-sponsored a regional seminar along with the American College of Utilization Review Physicians.

2) We formed a task force to promote better understanding between hospitals and skilled nursing facilities. This has greatly improved relations between these two institutions by facilitating and uncomplicating transfer procedures and other issues.

3) We became actively involved in the "Advocacy Alliance for Aging Patients", whose main goal is to improve the quality of care at skilled nursing facilities.

4) We have developed, with the Directors of Social Services, "Recommendations for Discharge Planning" when continuing problems relating to late or ineffective discharge planning was found during monthly concurrent monitoring of delegated hospitals by the PSRO review staff.

5) We have arranged for lectures on the PSRO program to be given to graduate level Health Care Administration students at a local university, at a two-day regional seminar of Utilization Review Coordinators, at a meeting of the Statewide University System Review Coordinators, and at a department head meeting of a large university hospital.

We can only foresee a decline in monitoring if a large PSRO system becomes a reality. The Area 22 PSRO discovered a doctor practicing for seven years without a valid license. One hosptial had five physicians operating without valid credentials. Without a vigilant, local PSRO, sanction activities against doctors and de-delegation proceedings against hospitals will have neither immediacy nor effectiveness. A large PSRO might allow an offending physician to continue practicing until it gets caught up enough to impose sanctions. De-delegation of offending hospitals will be slow in coming and much after the fact. A small PSRO is able to work quickly and incisively to see that abuses are detected early, are corrected quickly, and most importantly, do not occur in the first place.

In the long run, we cannot see how the centralization of PSROs can do any good. President Reagan proposed that we de-centralize bureaucratic tasks and allow them to be performed on a local level. In trying to appease Reagan's suggested budget cuts, why revert back to centralizing the PSRO mechanism? There is no indication that a large PSRO would be any more cost-effective than well-run local PSROs able to directly monitor the activities of its physicians and health care facilities, and made up of colleagues known in their localities. The most disastrous occurrence would be the destruction of the PSRO as a community responsive organization. Its ability to monitor and imrove the quality of health care will be restricted to an afterthought.

Area
PROFESSIONAL STANDARDS REVIEW ORGANIZATION
22

President
EDWIN W. BUTLER, M.D.

Vice President
DANIEL A. LANG, M.D.

Secretary
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MYRON STEIN, M.D.
CHARLES STONE, M.D.
PATRICIA MC DONALD

Executive Director
FRANK M. CROWLEY

March 30, 1982

Senator David Durenberger
353 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

Thank you for responding to my letter of March 12, 1982 concerning your bill S.2142, Peer Review Improvement Act.

As you know, Area 22 PSRO was ranked first last year among PSROs in Region IX. Yet we stand to be phased out if your bill passes.

In fact, if your bill passes, 16 of the top 25 ranking PSROs would be defunded -- and yet none of these highly efficient PSROs threatened with extinction are being represented at the hearings concerning your bill.

We are not only concerned with our continued existence, but with the future of the PSRO program, and it seems unreasonable that the representatives of the large and/or statewide PSROs seem to dominate the list of those asked to give testimony.

Enclosed you will find a list of the top 25 PSROs ranked according to performance, along with the number of Medicare discharges for 1980. A quick glance shows that 20 of the top 25, or 80%, of the most efficient PSROs, had under 75,000 Medicare discharges. Your proposed legislation would be a drastic move toward inefficiency in the PSRO program - the change toward fewer, larger PSROs would decrease the cost of the PSRO program, but unfortunately it would greatly decrease the cost-effectiveness.

It is imperative that the successful, cost-effective PSROs be rewarded with continued grants, while the ineffective PSROs be phased out. It won't merely do to cut costs if at the same time one cuts cost-effectiveness! And if the PSRO program becomes any less cost-effective, its opponents will bury the PSRO program.

Sincerely,

Frank M. Crowley

Frank M. Crowley
Executive Director

cc: Senator Alan Cranston
Representative Henry Waxman
Senate Finance Committee

Enclosures

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NATIONAL PSRO RANKING

	PSRO NAME	MEDICARE DISCHARGES
1.	South Carolina Medical Care Foundation	99,766
2.	Multnomah Foundation for Medical Care	32,667
3.	Delaware Review Organization	16,528
4.	NY Co. Health Services Review Organization	101,477
5.	Region X Peer Review Systems, Inc.	37,862
6.	Western No. Carolina Medical Peer Review Foundation, Inc.	30,549
7.	Montana Foundation for Medical Care	37,194
8.	PSRO of Queens Co., Inc.	58,157
9.	Utah PSRO	39,743
10.	Piedmont Medical Foundation	39,839
11.	Crescent Counties Foundation	38,695
12.	Central Massachusetts PSRO	23,408
13.	Wisconsin Professional Review Organization	143,914
14.	Capital Area PSRO, Inc.	18,897
15.	Area 9 PSRO of New York State, Inc.	40,496
16.	Foundation for Health Care Evaluation	138,452
17.	Delmarva Foundation for Medical Care	12,610
18.	Metrolina Medical Peer Review Foundation	47,617
19.	Area XXII PSRO	32,500
20.	Alabama Medical Review, Inc.	204,310
21.	Southcentral Pa. PSRO	75,776
22.	MediQual	29,398
23.	Professional Foundation for Health Care	42,969
24.	Riverside County PSRO	28,275
25.	Kings Co. Health Care Review Organization	69,475

Source: PSRO health data discharge set, 1980. HCFA, Washington.

TESTIMONY
FOR THE
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.
ON
THE UTILIZATION AND QUALITY CONTROL PEER REVIEW ACT OF 1982

THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. IS A VOLUNTARY ORGANIZATION OF PRIVATE PHYSICIANS FROM EVERY STATE IN THE UNION.

PSRO is an amendment to the Social Security Act signed into law October 30, 1972 as part of P.L. 92-603. Its multiple effects include restriction of Social Security beneficiaries to second class medical care under a new double standard which allows a quality care for private patients and homogenous mediocrity for government-regulated Medicare beneficiaries. PSRO is both unnecessary and incompatible with quality medical care. Its nationwide promotion by the H & H S bureaucracy and by some doctors is being done by misrepresentation and deception.

Proposed Senate Bill 2142 promises the same control. Proponents of S.2142 claim that it is designed to deregulate PSROs by allowing the government to enter into "performance based contracts" with PSROs already in existence and, where no PSRO currently exists, "any organization capable of carrying out the functions of PSRO". However, what does it matter if the federal government contracts out the enforcement of regulation or does it itself?

Furthermore. S.2142 would call for the creation of PSROs in each state and additional PSROs on a local level. Thus, the bill under consideration calls for more regulation, not less. Even a cursory reading of the bill reveals intent to create an even more pervasive PSRO program.

S.2142 will continue the restrictions imposed on American medicine by the current PSRO program:

(1) It represents rationing of medical services to cut costs and will reduce quality. It is fiscal control, not quality review.

(2) It invites unethical practice since computerized guidelines are an invitation to fraud.

(3) It introduces a foreign philosophy that medical care must conform to a federal cookbook for the treatment of all disease.

(4) It gives authority to a committee (PSRO selected, dominated and controlled) to decide upon admissions rather than to take recommendations by the patient's doctor.

(5) It allows no such thing as local control or local standards since every act, every review and every facet is directly under the control of the Secretary of Health and Human Services.

(6) It invades the confidentiality of patients' medical records, even in private doctors' offices by government agents, as is already being done with hospital records. Records kept by PSROs are public documents according to a ruling in a lawsuit decided in favor of Ralph Nader's Public Citizens Health and Research Group, April, 1978. Confidentiality is not assured by Section 1160 of S.2142.

(7) The physician is reduced to a technician since medical care will be governed by federal PSRO rules which will stamp cases by diagnosis for the number of days of treatment and will determine who, where and when to treat and to discharge patients.

(8) It stifles innovation since physicians are required to conform to established norms of care.

(9) PSRO has created a massive and expensive new bureaucracy which is totally unnecessary and has already cost millions of tax dollars.

(10) It makes doctors who sign up for PSRO agents of government who are no longer able to be advocates for their patients.

(11) Documentation from government files has proven that Medicare doctor fraud is insignificant. Doctors are not part of the contract between government and the hospitals. Under the original law and under the proposed

law, there is absolutely no basis for delegated or non-delegates status. The local PSRO entity is charged in any case, with complete responsibility for review of medical necessity and appropriate level of care.

(12) Signing of any PSRO agreement makes members of the medical staff agents of government. They are guided into a Memorandum of Understanding with the local PSRO. Doctors forfeit their Constitutional rights to remain separate, independent contractors when they sign for delegated review status. The Memorandum of Understanding is a contract, binding every member of the medical staff.

(13) If medical staffs become delegated by signing up, individual staff physicians become liable for the patient's bill if necessity of care is denied by the PSRO.

(14) PSRO takes valuable physician time away from patient care because the physician is required to justify in writing every decision which conflicts with government rules.

(15) PSRO doctors and staff are paid agents of the federal government. Currently, a lay director of a PSRO may receive up to $56,000 a year and a physician medical director may receive up to $62,500.

(16) PSRO drives a third party wedge between the doctor and his patient.

(17) PSRO, or whatever mandatory government utilization review is given, is a basic requirement for the nationalization of health care in America.

Currently it is impossible to confirm what membership is in any PSRO. We believe only a fraction are practicing physicians. In the new proposal review would not have to be done by physicians. Under S.2142 contracting arrangements are left totally up to the Secretary of the Health and Human Services. They may vary among areas and they may do private review contracting on their own, but always with absolute ties back to Washington.

Under Section 1155 a Medicare beneficiary is given the right to a reconsideration in case of a denial of benefits by the review organization. Section 1156 is a review of sanctions and penalties to be used against providers of care; i.e., physicians. These include fines up to $5,000.

Limitation of liability is provided for anyone working within the system or providing information to the review organization under Section 1157.

Other parts of S.2142 provide for Medicaid (Title XIX) review by the newly named body.

Senate Bill 2142 is PSRO with a new name with the Secretary in command.

S.2142 is only part, however, of the burgeoning role of the federal takeover of medical care. It represents only a fraction of the cost of federal health programs. The real importance of this legislation is its intent, similar to the intent of other federally imposed rules and regulations, to usurp state and local laws in order to bring the delivery of medical care in America under the control of the central government.

The federal government cannot pretend to be solely responsible for the financing, and it is axiomatic that what the federal government finances it must control, of health care for Americans under the Welfare clause of the Constitution since the states and local communities can make an equally valid claim to competence.

Since the responsibility for health care has been usurped by the unwise actions of earlier politicians, the cost of medical care has skyrocketed. Our present national bankruptcy, which has been brought about by incredible welfare spending of over 2,000 billion dollars in the past 16 years, is due to irresponsible promises by ambitious politicians. The health and welfare of Americans is worse, not better in our present welfare state, and the solution to the current health care dilemma is to get the government out of medicine.

The promise of "free medical care" is magical for the politicians, but it is disastrous since the demands for anything "free" always go beyond supply. Of course, it is not free. A statutory debit interest rate running at over $120,000 per minute attests to this.

Government funded health programs are a menace. The costs of Medicare, for example, have run from 10 to 20 times higher than official estimates at the time of the program's inception.

As a part of this system, PSRO, born out of P.L. 92-603 and aided and abetted by endless Federal Register and Transmittal Letter regulations, has produced the following system of health care for Americans: Nurses review records of patients and then report to doctors outside of the hospital on the status of Medicare patients inside the hospital. The outside doctors then make decisions that effect the very survival of those patients. It is inconceivable that any responsible representative would grant authority to nurses who are not trained in medicine and a remote reviewer who never examines or even sees the patient.

PSRO has never saved money; it has squandered millions. A preponderence of economists call PSRO a failure and a waste of taxpayers' money.

We cannot condone in America a system of rationing. We must not destroy free choice medical care in America. We need decisions now that emanate from statemen and patriots who will admit that unbridled government has created the very problems that we face today. Once having passed predictably unworkable public laws, Congress has repeatedly abandoned principled common sense to embrace short term political expedients that further compound the original errors. PSRO is in this tradition.

Finally, the Association of American Physicians and Surgeons protests the bias with which the Senate Health Subcommittee Staff selected testimony on S.2142 and S.1250. A preponderence of those selected to give oral testimony on PSRO were those individuals and organizations that stand to gain direct monetary benefit from the refunding of PSRO. No group of private physicians was allowed to testify because of the "many requests". The fact that many state PSROs were allowed to testify and many regional foundations for medical care (the same as a PSRO with a different name), as well as the American Association of PSROs and the National Association of Foundations for Medical Care, points to the bias with which the testimony was arranged. It is not insignificant that the American Association of PSROs and the National Association of Foundations for Medical share the same office and staff and objectives. If the purpose of a congressional hearing is to better understand legislation and the affects of proposed legislation and to ascertain for the members of the committee the truth, testimony on PSRO on April 1 was an aberration. If the purpose of such a hearing is to reinforce prejudices, the testimony arrangement was more than adequate.

STATEMENT
of the
AMERICAN NURSES' ASSOCIATION
on
LEGISLATION AFFECTING THE PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO) PROGRAM

We appreciate this opportunity to express our views with respect to the Professional Standards Review Organizations program. The American Nurses' Association is a professional association and labor organization representing approximately 170,000 registered nurses nationwide. We believe that the PSRO review system, in concert with governmental payment and planning agencies, can provide a means for assuring the quality and controlling the cost of services under Titles XVIII, XIX, and V of the Social Security Act.

Enacted in 1972, the PSRO program requires local physicians to police themselves in an effort to improve the quality and appropriateness of health care provided to Medicare and Medicaid beneficiaries, reduce the time spent in hospitals by such beneficiaries, and attempt to cut soaring health care costs. In last year's budget battle, we opposed attempts by the Administration to phase out the PSRO program, and we continue to believe that the alarming rate of inflation in the health care market would only be exacerbated by the elimination of PSROs.

In this statement, we would like to counter some of the agruments used against the PSRO program, respond to some of the recent proposals regarding PSROs, and offer some suggestions as to how the program can become more effective and responsive to the health care needs of the nation.

COST-EFFECTIVENESS

Perhaps the most frequent criticism leveled against PSROs is that they are ineffective because they fail to save enough money. The Congerssional Budget Office reported last year that the program expends slightly more than it saves in the aggregate. Accordingly, HHS was granted the authority by Congress to terminate not more than 30 percent of existing PSROs, along with several other changes. This was essentially an alternative to the Administration's desire to eliminate the program. However, there are statistics which counter CBO's claim, as H.C.F.A. has reported data which indicated that 70 PSROs achieved reductions in Medicare average length of stay between 1978 and 1979 of 647,634 days, and 62 PSROs achieved reductions of 249,480 days, resulting in an estimated savings of approximately $64 million.

Moreover, these conclusions with respect to the cost-effectiveness of the program are somewhat misleading. First, it must be remembered that the PSRO program was not created in a vacuum, but in response to the failure of the states, hospitals, and fiscal intermediaries to slow the increase in Medicare costs. We can only speculate as to the potentially higher rate of inflation which could have occurred if the PSRO program had not existed. Second, PSROs are not solely concerned with the issue of reducing the time spent by beneficiaries in the hospital; they also deal with the quality of care provided to these patients. Quality assurance activities are equally important when considering the value of the program. Unfortunately, evaluation of improvements in the quality of care in standard economic times is extremely difficult and has not been undertaken by CBO. In addition, the positive influence that PSROs have on physicians by making them more aware of inappropriate procedures and practices should not be overlooked. We believe that critics of the program are far too concerned with stressing cost while overlooking some of the less tangible benefits, such as improving the quality of care and educating physicians to practice higher quality medicine, which PSROs often provide.

We would like to give several examples which address this quality of care issue. According to a 1981 report of the American Association of Professional

Standards Review Organizations Impact Committee:

- Alabama Medical Review, Inc., the PSRO for the entire state of Alabama, found unacceptably high acute myocardial infarction mortality rates in thirty hospitals in the state due to delays in placing patients on cardiac monitors and to delays in starting IVs. PSRO physicians met with their peers to discuss these problems and arranged for inservice training and continuing medical eduction efforts. A follow-up audit documented a 71 percent improvement in timely placement of patients on cardiac monitors and a 62 percent improvement in the expenditious administration of IVs.
- The Central Piedmont PSRO located in Durham, North Carolina found that the mortality rate for acute myocardial infarction patients in one area hospital was 46.7 percent, a rate deemed much too high by the physicians. As a result, PSRO physicians met with their peers at that hospital, discussed the problems uncovered, and arranged for medical education. One year later, analyses showed that the mortality rate for AMI in the hospital had been reduced by 37 percent.
- The Region III Professional Review Organization in Findlay, Ohio identified a 67 percent mortality rate for AMI patients in one area hospital. The PSRO physicians met with the hospital chief of staff to discuss appropriate treatment methods as well as contraindicated treatment. In addition, due to the size and resources of the institution it was recommended that serious cases be considered for transfer to nearby facilities better equipped to handle them. The PSRO reported that the AMI mortality rate dropped from 67 percent to 0 percent with serious cases being transferred to a nearby coronary care unit.

- Ohio Area XI Physicians Peer Review Organization located in Ashland, Ohio found an overuse of the test type and crossmatch in twenty-four facilities affecting 8,000 patients. The PSRO informed staff of each hospital of the current blood utilization procedures recommended by the Red Cross and placed seven of the 58 involved physicians under concurrent review to improve blood utilization techniques. Results show that appropriate replacement of the type and crossmatch by the type and screen has occurred in 50 percent of the cases. Since the average type and crossmatch costs $40.00 while the average type and screen costs only $7.00, the PSRO estimates savings at $132,000.
- The Colonial Virginia Foundation for Medical Care located in Virginia Beach identified deficiencies in the practice patterns of twenty-six physicians in the PSROs area. Monitoring reports were sent to the hospitals in which these physicians practiced with requests for review and comment by those involved. Special chart monitorings of these physicians' cases were conducted. Discussions of deficiencies with the involved physicians' were conducted. Concurrent review of these twenty-six physicians was intensified. Results show that twenty-four of the twenty-six physicians demonstrated improved care. The two physicians who did not demonstrate improvement are under continued monitoring.

These examples clearly portray the valuable contributions made by PSROs with respect to quality of care, and argue strongly against the contention that the program is not cost-effective.

CONSOLIDATION OF PSROs

The Department of Health and Human Services has been authorized to terminate not more than 30 percent of the 182 PSROs that existed last October. As of February, 1982, approximately 38 PSROs had been terminated. Both S.2142 and S. 1250 would require the Secretary to consolidate and reduce the number of PSROs, arguing that many existing PSROs are too small and inefficient to justify the expense of continued operation.

We have no argument with the desire to eliminate any PSRO which performs poorly, provided this is coupled with continued or increased support for PSROs which are effective and efficient. However, the existing PSRO law does, in fact, provide an adequate remedy for poor performance by a given PSRO - namely, replacement. The law provides that the responsibility to evaluate PSRO performances lies with the Secretary, and lodges with him the authority to replace ineffective PSROs. He may replace a PSRO with an alternative group of physicians, a state or local health department, or a fiscal intermediary. The Secretary should assert this authority to differentiate among PSROs, insist upon improvement or terminate those performing poorly, and continue to support and encourage those PSROs which have become viable and responsible entities.

An ineffective PSRO should be promptly replaced, but the Congress should not, because of individual poor performance, condemn the entire group of PSROs or the underlying concept. So long as consolidation of or reduction in the number of PSROs is accomplished in a rational manner, with due consideration of the possibility of replacing entities which perform poorly, it could potentially result in an improvement in the quality of the overall program.

PARTICIPATION OF PROPRIETARY ORGANIZATIONS

Under current law, priorty in designation of a PSRO is given to nonprofit organizations which are composed primarily of physicians who practice in the area in which the PSRO is located. This is to insure that local physicians in active practice would be in charge of the professional review of health services. If such a local nonprofit organization is lacking, then (and only then) may the Secretary select another type of organization to handle local review responsibilities.

S. 2142 would significantly change existing policy, and eliminate priority status for nonprofit entities. Thus, proprietary organizations would be permitted to compete equally for PSRO designation with their nonprofit counterparts. Although we agree with the avowed purposes of encouraging cost-effectiveness and efficiency, we remain skeptical about proprietary participation for several reasons. First, we do not understand the need for a profit motive in the operation of a PSRO, since many effective groups currently operate without the enticement of additional income. Second, we have never been convinced that the profit motive actually increase efficiency, and are unaware of any studies which conclusively prove that proprietary involvement in the health care market actually lowers costs. Third, we fear that the profit motive, rather than the quality of care, will become the overriding concern of an organization which must ultimately answer to its stockholders. Finally, we are wary, since the Administration has called for the elimination of government funding for PSROs, that the promotion of proprietary involvement may be the first step toward eventual withdrawal of active involvement by the federal government in the program.

For these reasons, we feel compelled to reject the notion of eliminating the provisions that priority consideration must be given to nonprofit entities, and would prefer to see the status quo maintained.

INCREASED PARTICIPATION BY NURSING

In the Omnibus Reconciliation Act of 1980 (P.L. 96-499) Congress mandated that membership on the National Professional Standards Review Council, along with the Statewide Professional Standards Review Council Advisory Group, would be accorded to a registered nurse. We believe this action was a positive step toward recognizing the valuable contributions made by registered nurses in the peer review process. We were disappointed, however, that participation by nurses on individual PSROs was not included in the legislation.

Professional registered nurses already play a significant role in PSROs in collecting data and reviewing cases yet have no voice in policy. Nurses constitute the largest single group of health care workers, are the profession most continuously involved with the patient, and provide care which is both pervasive and constant. Registered nurses, by virtue numbers and the types of practice in which they are engaged, have a significant impact on the cost and quality of health care services. More than one million nurses provide services in every type of health care setting, and, in inpatient facilities, provide 24-hour, 7-day week care.

Individuals are admitted to and remain in health care facilities because they have a need for continuous professional health management. Such need may be related to medical and/or nursing management of a health problem. In some instances, such as the need for long-term care, the most valid criteria may be related to nursing care rather than medical care. The nurse frequently is the health care professional best able to determine the level of services needed by the patient, and whether the facility is capable of meeting these needs.

It seems apparent that the functioning of PSROs would be strengthened with broader participation by professional nurses, and particularly by the inclusion of nurses where critical decisions are made about health care services. As we have stated, there currently is extensive participation by registered nurses with respect to PSROs, even though the statute does not address specifically their active involvement. Nurses serve on PSRO boards of directors, as associate directors, directors of operations, directors of review, and review coordinators. Virtually all of the hospitals under PSRO review have at least one registered nurse conducting review. But the law refuses to recognize the ongoing contribution of nurses to the program by not mandating their inclusion in local PSROs.

Professional Standards Review Organizations were originally authorized by Congress to help insure the quality of health care and control costs through the process of professional peer review. However, at present, only physicians may serve on local councils and participate in policy decisions. The review of health services is stated as the intent of the PSRO program, but, in fact, the decision-making and major review activities revolve around physician services alone. This obviously limits the effectiveness of these bodies. If the PSRO is to truly provide peer review of health care delivery, it must contain representatives of other categories of health professionals in addition to physicians.

We would like to suggest an amendment to existing law which would require the membership of two registered nurses on each local PSRO who would be elected by current members of the organization, and would enjoy equal status with physician members. This would remedy the existing discrimination against non-physician providers, and could only improve the quality and effectiveness of peer review.

CONCLUSION

Again, we wish to reiterate our support for the existing PSRO program, and we believe the examples we have offered more than adequately prove the success of the program. We request the support of the Subcommittee with respect to greater involvement by registered nurses in the peer review process, and thank the Subcommittee for the opportunity to present our views on this issue.

April, 1982

JOHN P. PERRIN, DIRECTOR
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WASHINGTON, D.C. 20003 TELEPHONE 202 554-5245

American Osteopathic Association

March 29, 1982

The Honorable
Bob Dole
Chairman
Senate Finance Committee
United States Senate
Washington, D.C. 20510

Dear Chairman Dole:

I write on behalf of the American Osteopathic Association with reference to S. 2142, which has been referred to the Finance Committee. This legislation, which is offered "to provide for a new system of utilization and quality control peer review under the Medicare program," has been carefully reviewed by the AOA's Council on Federal Health Programs. While the proposal has some merit, there are several elements of the bill which cause us to have serious concerns which we wish to share with you.

At the outset, we would note that the American Osteopathic Association has historically encouraged and supported true peer review. Most recently, in July 1981, the AOA House of Delegates affirmed the Association's commitment "to promote and facilitate true peer review among and through its members."

The foregoing excerpt from the AOA's position statement on peer review immediately explains one of our principal concerns relating to the proposed legislation. Specifically, Section 1152 of the bill will permit contracts with entities other than physician organizations. While such a result was possible, under the PSRO program, it could only occur where appropriate physician organizations did not come forward to request designation. We submit that the language of Section 1152 represents a major departure from the concept of peer review as a quality assurance mechanism and moves it into the realm of purely fiscal review. While fiscal review has always been a legitimate element in the review process, we believe that abandonment of the principal thrust of the PSRO program, toward assuring quality in medical care delivery, disserves the American patient.

Our remaining concerns relate to two elements of Section 1156.

First, that section sets up the possibility of a provider being excluded from eligibility on the basis that his services were not provided "economically." Under existing law, the provider is charged with the responsibility of providing only those services which are medically necessary and appropriate. A determination of compliance with that charge can be made on a reasonably objective basis. However, we submit that a determination of what constitutes "economical" delivery is susceptible to widely varying interpretations. Granting an administrative agency authority to exclude a provider from participation, upon such subjective criteria, creates an environment in which arbitrary decision making can occur.

Our concerns relative to the new "grounds" for exclusion are compounded by a further provision in Section 1156. Specifically, the Secretary is given final authority for determination of exclusion, predicated on the reports of the peer review contractors. If the Secretary fails to act on a recommendation for termination within 120 days the provider is automatically excluded from eligibility. Under the provisions of the bill, then, it is possible for a provider to be terminated, without review and an affirmative decision by the Secretary and without prior, formal, fair hearing. We believe that such a scenario violates the principle of due process.

In conclusion, we would underscore that we offer the foregoing criticism with constructive intent. Accordingly, we ask your careful consideration of the issues raised. We will be pleased to provide, to you or the Committee, any further information or assistance you might desire.

Sincerely,

John P. Perrin
Director

JPP/jf